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1950



TRAINING IN CLINICAL PSYCHOLOGY

By the STAFF *of the* CONFERENCE *on* GRADUATE EDUCATION *in* CLINICAL PSYCHOLOGY *held at* BOULDER, COLORADO *in* AUGUST *of* 1949

Sponsored by the AMERICAN PSYCHOLOGICAL ASSOCIATION, *under grant from the* NATIONAL INSTITUTE *of* MENTAL HEALTH, UNITED STATES PUBLIC HEALTH SERVICE, FEDERAL SECURITY AGENCY • *Compiled and edited by* VICTOR C. RAIMY

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Foreword

This book is about clinical psychology, one of the youngest but also one of the most rapidly growing members of the family of professions concerned with the problems of mental health. More specifically, it deals with the problems of training for members of the profession of clinical psychology. However, since professions are to such a large extent a function of the training of their members, it is not possible to discuss training for a profession without becoming immediately involved in a consideration of the goals, methods, and practices of that profession.

In one sense the development of the profession of clinical psychology constitutes something of an educational experiment, in that clinical psychologists are being trained both as scientists and as practitioners. Most professions base their practices on one or more sciences and train their future members in a separate professional school. In contrast, clinical psychologists are trained concurrently in both the theoretical (scientific) and applied (clinical) aspects of psychology. This training occurs not in professional schools but in the graduate schools of our colleges and universities. Many of the problems discussed in this book are related to this relatively unique attempt to combine two types of training that are ordinarily provided in separate curricula.

The period following World War II was characterized by greatly increased demands for clinical services; these demands resulted in a very rapid expansion of training programs. By 1949, nearly 1500 persons were being trained in doctoral programs in some 60 different institutions. Those of us whose professional activities per-

mitted us to see these programs in broad perspective felt that the training was good but saw also that it varied markedly from institution to institution. Thus there appeared to be a need for an over-all review of our training activities. Were we on the right track? Just what are society's needs for the services that clinical psychologists can provide? And, of course, what kinds of training are needed to produce good clinical psychologists?

These and many other questions constituted the agenda of the Boulder Conference. With expenses underwritten by a grant from the United States Public Health Service, the American Psychological Association planned the Conference and selected seventy persons with major training responsibilities to participate in the critical review of training and in the planning of future steps. The reader will find that the Conference was anything but a mutual admiration society. Perhaps, because we were trained first as scientists, we tended to be extremely critical of almost every aspect of training and current practice in clinical psychology. Participants came to the Conference with many honest differences of opinion; these differences are reflected in this report of our discussions. Some of them are still unresolved, and will be decided only on the basis of further experience. The surprising thing, however, is the degree of unanimity we arrived at on most of the problems we discussed.

We trust that this frank account of the discussion of representatives of a young profession attempting to take stock of itself and to chart its future development will be of use not only to clinical psychologists but also to members of other professions in the mental health field.

The profession of psychology is greatly indebted to Dr. Victor Raimy for undertaking the arduous task of preparing this report of the Conference. Some of the thinking that went on at Boulder was embodied in the sub-group reports that were reproduced and distributed to the participants day by day during the Conference. Many other important ideas were expressed only in the general discussion sessions, for which wire recordings were available. However, in spite of the fairly detailed agenda, neither these daily reports nor the recorded transcripts were suitable for publication. In part

because he had already served the Conference so effectively as an Administrative Officer, Dr. Raimy was asked to assume the responsibility of sifting and organizing these extensive materials into a report of the Conference that would be maximally useful to persons not participating in it. He accepted this assignment, even though it meant giving up most of his other professional obligations for several months, and has written a document that faithfully reflects both the mood and the content of the Conference proceedings. The ideas and conclusions are those of the Conference participants, but their systematic and coherent presentation is the work of Dr. Raimy.

We are deeply appreciative of the foresight and generosity of the United States Public Health Service in providing the grant that made the Conference possible. We are also grateful to the University of Colorado not only for making Dr. Raimy's services available but also for providing a pleasant environment to which we could retreat to think and talk—well away from our daily responsibilities. And finally, we appreciate the devotion of the participants, most of whom gave up what would have been their vacation periods to follow a very rigorous Conference schedule.

THE EXECUTIVE COMMITTEE
Wayne Dennis
John C. Eberhart, *ex officio*
Karl F. Heiser, *ex officio*
William A. Hunt
Ann Magaret
James G. Miller
E. Lowell Kelly, Chairman

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INTRODUCTION

*Mental Health and Clinical Psychologists**

by

ROBERT H. FELIX, M.D.

Director, National Institute of Mental Health
U. S. Public Health Service

I feel that I am in attendance on a most important and significant occasion. The pooling of information and the exchange of ideas in the field of training in clinical psychology is of vital importance in the National Mental Health Program, and it is with great satisfaction that I come here to the campus of my own alma mater to be a part, even though a very small part, in the deliberations of these two weeks.

The most pressing need in the mental health field at the present time is for an adequate supply of well trained individuals, among the most important of whom are clinical psychologists. I should like to stress the fact that we need not only an adequate supply of personnel but an adequate supply of *well trained* personnel. When one considers the scope and variety of activities in the field of psychology that are essential to a properly balanced and effective nationwide mental health program, one is fairly staggered by their magnitude. Any listing of the activities in this broad field but sketches in bold strokes the horizon toward which we are advancing and beyond which we will find other horizons. They do not represent limitations or boundaries and must not be considered as such. It is much better that all of us feel somewhat frustrated by the size of our task and our inability to complete it than that we

* Delivered at the American Psychological Association Conference on Graduate Education in Clinical Psychology, Boulder, Colorado, August 20, 1949.

feel a sense of comfort from outlining frontiers that mark the periphery beyond which we will not travel.

The development of the present concepts of the scope of clinical psychology as I understand them parallels the development of the present concept of mental health in general. This development has meant the assumption of new, different, and not-too-well-understood functions by more and more psychologists, functions that have taken them out of the classroom, the laboratory, or the clinic or hospital, and have made them an essential part of the forces for the promotion of positive mental health, with responsibilities for service and for planning and development of as yet not clearly defined activities. They cannot escape being a part of these forces, even should they so wish. They will serve either directly or indirectly.

As late as a half century ago, the custody, care, and treatment of the mentally ill was the extent of the activities in the mental health field. The psychologist's clinical functions consisted by and large of administering tests, usually to determine the presence or absence of mental deficiency. The care of the mentally ill was almost exclusively the responsibility of the mental hospital, and only there would one find most of the psychologists who were dedicating their lives to the clinical side of their profession. As the socio-economic development of a community progresses, however, the conception of mental health develops with it. At the lowest level no conception of mental health exists, and only mental ill-health in its flagrant forms is recognized: that is, the more flamboyant psychoses and grave cases of mental defect. From this point, the conception progresses to include recognition of the transient or milder psychoses, the higher degrees of mental defect, and the grosser forms of psychoneuroses. Later, certain forms of character disorder are also identified.

Growing understanding of the genesis and nature of psychoneuroses produces an increased interest in the psychological problems of childhood, and it is usually in this area of the mental health field that clinical work first leads to preventive thinking. Preventive thinking at first is restricted to the early identification and treatment of emotional and personality disorders, particularly in children; but

such thinking is still on the treatment level. True preventive activities develop at a much later stage and in connection with a broadening concept of psychological processes that includes their influence upon physiology, and vice versa, and upon the social aspects of interpersonal and intergroup relationships. Finally, mental health is thought of in its most positive frame of reference, which is not primarily the prevention of illness or defect but, more importantly, the development and practice of techniques that will be conducive to a more robust and wholesome state of mental health. The development of the National Mental Health Program within the Public Health Service has proceeded along these lines, passing from the era of only hospital care for the mentally ill to that of broad community programs, which are now being developed by the states throughout the nation.

This change has been rapid—so rapid in fact that it has been almost impossible for any one person to keep abreast of all of the aspects of the development; yet it is vital to the mental health of our nation that those whose professions are in the mental health field clarify their thinking as quickly as possible and develop clear concepts of where we are going and how we are to get there. The role of psychology in this program is critical and vital. The first need is to understand what should go into the training of psychologists who are to work in this broad field and how this training can be given in a reasonable span of time. At the same time it must never be forgotten that the individual whom we call a clinical psychologist, although he is desperately needed, is only one type of psychologist who must make a contribution to the total effort. The service he renders to the community in which he works is dependent upon the contributions to the field made by the social psychologist, the physiological psychologist, and the experimental psychologist—men working on those basic fundamental problems that may not at first seem to bear directly upon the problem that is the principal concern of the mental health worker.

It would be a tragic mistake if effort were channeled into the development of clinical psychologists at the expense of the other psychological fields, without which the clinical psychologist becomes

little more than a technician. The broad scope of the work included under clinical psychology can be readily understood when one thinks for a moment of the functions such a person is expected to perform. These include diagnosis, therapy, research, training, and consultation. Each of these functions, to be properly performed, requires careful training and supervised experience, which in turn require first and foremost the production of more teachers with the broadest possible view and very extensive training and experience. These supervisors are in a critical position in the training of the young clinical psychologist, and I respectfully submit here that the problem of their training requires the most careful and critical consideration by this group. If my experience as a medically trained person is worth anything, I would say that, although the best possible didactic and laboratory training is very necessary, the techniques and attitudes learned in clinical clerkships, wardwalks, internships, and residencies leave a lasting impression and are the shapers of attitudes and concepts which, for better or for worse, last a lifetime.

Although I recognize the dangers involved in discussing problems outside one's field of competence, nevertheless, because of my firm conviction regarding the critical role to be played by the clinical psychologist, I hazard to enumerate here a more detailed listing of the functions of the clinical psychologist as I see them. It seems to me that the diagnostic function includes much more than the determination of intellectual status. I, for one, in my clinical practice of psychiatry have never been too concerned about the numerical figure supplied me by a psychometrist to indicate the intellectual level of a patient. Were this all I wanted in a diagnostic way, I would not use a psychologist at all. I can tell to my own satisfaction, within reasonably broad limits, whether an individual is very dull, dull, of average intelligence, or above average. If I wish a somewhat finer determination, I can either do my own intelligence testing or have it done for me by a psychological technician. There are other diagnostic data that I need and that the properly trained clinical psychologist is peculiarly prepared to: (a) supply me, (b) interpret for me, and (c) confer on with me in planning the treat-

ment of the case in the light of his findings. I refer to procedures for the evaluation of personality structure and dynamics and for the exploration and appraisal of vocational interests and potentialities. Much of this information does not come as much from test material as from the clinical experience and judgment of a psychological diagnostician—the properly trained clinical psychologist. As we move into the broad field of mental public health, however, there is another diagnostic role that the clinical psychologist must be adequately prepared to fill. It is essential that we know the size of our mental illness problem in order to lay strategy to attack it, and this means the proper identification of mental disorders that exist in a community undetected until a special effort is made to identify them.

The identification of mental illness or emotional problems in a community, while of scientific interest, is in many ways a disservice to a community if reasonable facilities are not available to deal with the problems discovered. This means the utilization of all therapeutic skills available and the development of potential skills to the point at which they can be useful and relied upon. The fulfilling of this function, it seems to me, involves the treatment of psychological disorders and the promotion of the mental health of the individual or the group by the utilization of appropriate and established psychological techniques and principles of therapy under psychiatric direction. As more and more clinical psychologists enter active working relationships, in hospitals, clinics, and elsewhere, the psychiatrists and other mental health personnel there have naturally developed some conflicts and problems centering about the specific functions of each. As this relationship continues, and each learns to know the other better and to understand his sphere of competence, and as all grow to understand the tremendous scope of mental health work, these conflicts will inevitably decrease.

Although the fully occupied clinical psychologist may have little time to fulfill his research function, he must possess reasonable competence in this field if he is to maintain his clinical facility and continue to have the urge to explore that which he does not understand. He should be capable, at both the fundamental and the

applied level, to plan and formulate research programs; to define, reasonably well, problems for investigation; and to interpret and validate data obtained. This function also includes the postulation of hypotheses and the determination of experimental design. The properly trained clinical psychologist must be competent to give proper instruction and technical direction to graduate students serving psychological internships in hospitals and clinics. Furthermore, and of equal importance, he must be prepared to give formal and informal instruction in the principles and practices of clinical psychology to physicians, nurses, social workers, administrators, and students of various disciplines.

Public health practice at its best is a mass approach to problems of health. It involves the changing of concepts and ways of life in order that a transition can be made smoothly and permanently from a less hygienic to a more hygienic mode of living. This mode of living ranges all the way from adequate methods of sewage disposal to the most wholesome and mentally healthy types of interpersonal relationships between employer and employee, between members of the family constellation, between individuals in a community, and between groups. The clinical psychologist must be prepared to give proper consultation in these fields as a part of his functions in an organization or a community.

If one accepts what has been set forth here as a proper function of a clinical psychologist, one cannot help but approach the problem of what constitutes adequate training of the clinical psychologist with deep gravity and soberness. You who represent the departments of our universities offering such training have a tremendous responsibility, for your products will be expected to carry out these functions in all the length and breadth of our land and will inevitably be given these responsibilities. How they are prepared, you alone can determine; and yours will be the credit or the blame. I am fully convinced of the indispensability of the clinical psychologist in a mental health program, and have advocated from the start and shall continue to advocate the widest possible utilization of such personnel. All of us are deeply concerned that your deliberations during this conference produce concrete realistic and

workable recommendations that will be acceptable to the training centers. The time is later than you think. The mental health program is going forward, and neither you nor I nor all of us can stop it now because the public is aware of the potentialities of a good mental health program. We must produce and produce now or reconcile ourselves to the inevitable results of our failure.

I have been associated at one time or another with a number of you here, and that association has played a great part in formulating my concepts of the role of the clinical psychologist in the broad field of mental health. My acquaintances with you have also convinced me that the hopes of all of us are not in vain and that we shall see a better trained, more competent, and more versatile clinical psychologist appearing on the scene in the future, without compromising or crippling those other, equally important areas in the field of psychology.

TRAINING IN CLINICAL PSYCHOLOGY

CHAPTER 1

The Background and Organization of the Conference

In August of 1949, a conference supported by the National Institute of Mental Health, United States Public Health Service, convened at Boulder, Colorado, to consider problems connected with the training of clinical psychologists. A total of seventy-one representatives, from training universities, mental health service agencies, and allied professions met daily for two weeks in small sub-groups and in general sessions. Although this chapter is devoted mainly to a description of the background and organization of the Conference itself, a thumbnail sketch of clinical psychology in 1949 may help the reader to understand why the United States Public Health Service provided financial support and why the American Psychological Association undertook, as sponsor, to plan and organize the meeting.

CLINICAL PSYCHOLOGY IN 1949

It would be difficult to select a more appropriate year than 1949 in which to consider the myriad problems involved in the training of clinical psychologists. Immediately following the end of World War II in 1945 training institutions throughout the country feverishly organized programs in an attempt to meet the unprecedented demand for persons professionally trained in the mental health fields. The need for the determination of policies and for the planning of programs was perhaps more acute in the case of clinical psychology than in the allied mental health fields of psychiatry and

psychiatric social work, since in these latter professions educational programs had been fairly well settled before the war. The problems of psychiatry and psychiatric social work were largely those of increasing facilities and the recruiting of staff members to meet the vastly increased number of students. In clinical psychology (and also in psychiatric nursing), however, policies and goals had to be developed, staff members had to be employed and oftentimes trained, and facilities in the universities and in the field had to be tremendously expanded or even started from scratch. Simultaneously practical methods had to be developed for training large numbers of graduate students to implement the recently devised policies and goals. All this went on in the face of competition by universities and service agencies for the relatively small number of trained clinical psychologists, and in the inevitable confusion caused by the knowledge that the staff and available facilities could barely care for the qualified students already enrolled, let alone the vast number of applicants clamoring for admission. Most of this planning and organizing went on in relatively isolated university settings; faculty members did not have time to travel about and meet with other departmental staffs to consider common problems of policy and methods, nor was inter-university planning a tradition in graduate training.

By 1949, a scant three years after the initial organizing activities had been started, psychology departments had begun to settle down and to feel that emergency conditions had abated and that the time for long-range planning had arrived. There was considerable curiosity about whether one's own training program bore much similarity to training under way in other universities. True, most university departments had received a number of visits from representatives of government agencies interested in developing more and better training facilities for clinical psychologists and from members of the American Psychological Association's Committee on Training in Clinical Psychology; but these visits were largely for purposes of appraisal. The needed opportunity to compare notes and to puzzle out major items of policy with other members of the profession, also engaged in training, did not arrive until the meetings in Boulder.

This account of the immediate postwar conditions should not be taken to imply that there had been no training of clinical psychologists before the war. On the contrary, some universities and field centers had been training clinical psychologists for several decades; but this prewar training could generally be described as sporadic in both content and methods. Very few graduate schools had a formalized training program in the clinical area, although courses in individual and group testing were given by most psychology departments. A few university clinics were working intensively on children's maladjustments, along with the psycho-educational problems of children and college students. Facilities for practical experiences, however, were confined largely to testing and to a few counseling courses, and internships as formal requirements for the Ph.D. or the M.A. were practically unknown. Nevertheless, despite the lack of formal training programs, a fairly large group of psychologists within the universities, and a much larger group on the outside, had been devoting their time rather exclusively to service work with children and adults in institutions, courts, and social agencies. A very few, mostly in the largest cities, were engaged in private practice. Research was being carried on in numerous centers; however, with a few notable exceptions, it was confined to studies of children's problems, development and validation of tests, and occasional participation in mental health problems in medical settings.

It would probably be fair to state that, before the war, clinical psychologists as a group had paid relatively little attention to the problems of psychotherapy, although a few individuals had begun to investigate problems of therapy and a few had started training programs in those universities and institutions which included psychotherapy in their curricula. It was also true that the majority of persons with clinical training had left the universities after obtaining the M.A. degree in one or two years of study. However, the trend toward recognizing the clinical area as a respectable major for the Ph.D. degree had become noticeable in the five or ten years just prior to the war.

Relatively little has been written about the historical development

of clinical psychology, although a good survey can be found in C. M. Louttit's article, "The Nature of Clinical Psychology," which appeared in Volume 36 of the *Psychological Bulletin* in 1941. Future histories in this field will probably place the period of World War II and its immediate aftermath as the time when clinical psychology changed from a loosely organized, largely academic group of psychologists into a profession with some status in the mental health field.

The armed services made extensive use of clinical psychologists in screening work at induction centers, in diagnosis and treatment at base hospitals, and in research immediately related to neuropsychiatric problems of the war. Quite apart from the psychiatric disorders brought on by the war itself, selective service statistics had aroused government agencies, the mental health professions, and the general public to a recognition of the enormous number of mental casualties in the population. Following the war, the very active Veterans Administration focused attention upon the burden that the federal government would bear for many years as a result of service-connected neuropsychiatric disabilities. In fact, the Veterans Administration, on the basis of World War I statistics, now estimates that the peak hospitalization of veteran patients will not come much before 1975, or approximately thirty years after the end of the war. Over half the hospital beds in V.A. hospitals are occupied by neuropsychiatric patients.

While the government and the medical profession were working on these very practical problems, the general public was becoming quite conscious of personal mental hygiene problems and the possibility of help from professional sources. Psychoanalytic, psychiatric, and psychological theories were becoming matters of rather general interest, partly as a result of the war-engendered stimulation, but also as a result of discussions in popular literature, college courses, public lectures, and newspaper columns. Immediately following the war, the best sellers in the nonfiction field were those books written largely as popularizations of current personality theories and devoted to "improving your personality" or obtaining "peace of mind." Self-improvement books are by no means a new phenomenon, but

those published in the 1940's were taking on more and more of a psychiatric and psychoanalytic tinge.

All these developments, plus the fact that in the clinical field there were many well-paying but unfilled positions, produced a very considerable interest in psychology in general and clinical psychology in particular. In the Veterans Administration alone, it was estimated that there were more openings for clinical psychologists at the Ph.D. level than there were qualified people in the country. State hospitals, general hospitals, and social agencies were also creating an increasing demand for clinical psychologists.

This, then, was the atmosphere in which clinical psychology went through its most difficult period of trying to organize its basic goals and fundamental procedures in training. Three outstanding developments crystallized the general social and professional interest in clinical psychology and were immediately responsible for the rapid postwar growth. These three developments were interrelated.

First of all, the Veterans Administration, unable to employ a sufficient number of psychologists to meet its immediate—let alone future—needs, established a cooperative program with the best prepared universities to train large numbers of clinical psychologists. The V.A. program offered traineeships to students selected by the universities. The program was specifically set up to provide these trainees with clinical training, and they were paid adequate salaries for their half-time work in V.A. hospitals and mental hygiene clinics.

Secondly, in an effort to increase the supply of trained mental health personnel, the United States Public Health Service began to provide grants in the field of clinical psychology to training centers for the purposes of staff procurement and the general development of departmental and practicum facilities. To attract students with outstanding potentialities into the clinical field, a number of well-paying fellowships were also established at many of the universities by the Public Health Service. It should, of course, be noted that both the V.A. and the Public Health programs were set up to help the four mental health fields: psychiatry, psychiatric social work, psychiatric nursing, and clinical psychology.

The third development was an immediate outgrowth of the two previous programs. The American Psychological Association was requested to furnish the V.A. with the names of universities that provided satisfactory programs of training in clinical psychology, and that were thus eligible to participate in the V.A. program. The APA immediately appointed a committee, later known as the Committee on Training in Clinical Psychology, which began a series of investigations and eventually produced a recommended program of training and an accreditation procedure for universities training clinical psychologists.

Thus the Veterans Administration, through its training program, enabled universities to select a large number of well-qualified students who received not only financial aid but also opportunities for clinical experience in well organized neuropsychiatric centers. The Public Health Service in turn provided financial support to universities and intern training centers that were not able to carry all the costs of expanding and improving their training programs. Finally the Committee on Training stimulated psychology departments into attempts to organize truly professional training programs.

As a result of both the activity produced by the general interest in the mental health fields and the specific developments taking place in clinical psychology, the United States Public Health Service saw a need for a better understanding among training centers. Staff members of the Public Health Service had visited large numbers of training centers. They, together with psychologist consultants to the Service, were very much aware of the rapid changes that were taking place in the field. Wide variations in practice and thinking were becoming apparent. Staff members of all training universities had been so busy with their day-to-day work that they had not had time to think about where they were going or how they wanted to get there. Therefore the Public Health Service decided to support conferences in the mental health professions, conferences that would give careful consideration to basic policies and to the development of specific, coordinated plans for the future. This decision resulted in the Conference at Boulder.

The Conference, as was pointed out at the beginning of this

chapter, came at a most opportune time for clinical psychology. While the training centers had had three years' experience with their new and vastly expanded training programs, the programs themselves were not so solidified that they could not be revised in terms of more generally recognized goals. Thus the Conference gave clinical psychologists an almost unique opportunity to consider what kind of a profession they wanted, and to make an honest attempt to see how their profession could best help meet the needs of society.

PLANS FOR THE CONFERENCE

The Conference on Graduate Training in Clinical Psychology was first conceived at a meeting of the Training Committee of the National Institute of Mental Health and was approved by the National Advisory Mental Health Council in December, 1948. It eventually took place between August 20 and September 3, 1949. Funds from the National Institute of Mental Health were turned over to the American Psychological Association to defray expenses.

The American Psychological Association's Committee on Training in Clinical Psychology might logically have been assigned responsibility for the Conference. Since that Committee, however, had been concerned primarily with accrediting universities, it was felt that another group should plan and conduct the Conference. The APA Board of Directors, therefore, set up a plan to obtain a Conference Executive Committee to be composed of two persons from the Committee on Training in Clinical Psychology, two representatives elected by university departments themselves on the basis of a mail ballot, and one person to represent the Committee of University Departmental Chairmen. Since training programs for clinical psychology had been developed within the framework of academic departments of psychology, the departments themselves bear a large share of the responsibility for professional training.

As finally constituted, the Executive Committee included E. Lowell Kelly and Ann Magaret as representatives of the Committee on Training; William A. Hunt and James G. Miller as depart-

mental representatives; and Wayne Dennis as representative of the APA Committee of University Departmental Chairmen. John C. Eberhart and Karl F. Heiser, representing the United States Public Health Service and the American Psychological Association, respectively, served as ex officio members of the Executive Committee. Victor Raimy of the University of Colorado served as administrative officer. Dr. Kelly became chairman of the Executive Committee and later served as general chairman of the Conference.

During preliminary meetings, the Executive Committee decided that participation in the Conference should be limited to those who were immediately concerned with problems of training in the universities and in the field agencies, particularly at the doctoral level, the level accredited by the American Psychological Association. Forty-two universities had received Association approval, in some degree, for their training programs. Representatives of forty-one universities attended.

In addition to university representatives, clinical psychologists were selected to represent supervisors of typical field training installations, such as V.A. and state hospitals, community agencies, and a medical school clinic. Because of the many relationships with government agencies, officials from the Veterans Administration training program, the Surgeon General's Office of the Department of the Army, and the United States Public Health Service were also invited. Finally, representatives from related disciplines were invited to represent the American Psychiatric Association, the American Association of Psychiatric Social Workers, psychiatric and public welfare nursing, and the Division of Counseling and Guidance of the American Psychological Association. A complete list of representatives' names and of organizations represented is found in the Appendix.

By circulating lists of questions relating to problems of training, the Executive Committee eventually settled upon a preliminary program that began with discussions of fundamental problems and later took up the more specific details of training. As was anticipated, the original program was revised several times during the

Conference, as need for more time on particular problems became apparent.

The Conduct of the Conference. Since this was to be a working conference, the final total of 71 participants had to be divided into smaller groups, although general sessions were held at least twice daily before sub-group meetings took place. By shuffling cards, each of which contained the name of one participant, a random division into sub-groups of 17 or 18 persons was arranged for each morning, afternoon, or evening session. Thus in the course of the fourteen days, opportunities were provided for obtaining points of view from all participants, meeting in constantly changing sub-groups. This device apparently had both advantages and disadvantages; although it provided the possibility of maximum acquaintanceship, it also precluded the organization of sub-groups that might have become accustomed to working together as a group. For the purposes of the Conference, however, it apparently worked well, since new approaches and new ideas were constantly stimulated by the changing character of the sub-groups.

Each participant was designated at least once as chairman and once as recorder for one of the sub-groups; thus the necessary administration and report writing were distributed among the seventy-one persons in attendance. All the sub-groups met for two hours to discuss the same general topic. Each sub-group prepared a written report covering its deliberations and major conclusions. The chairmen and recorders for a particular topic then attempted to prepare a general report for each topic, although all sub-group reports were duplicated and distributed to all participants as preparation for the general session devoted to each of the topics. All the general sessions were recorded on wire, and the typescripts from the recordings were later made available.

The Resolutions. A number of formally approved Conference resolutions were obtained during the Conference by systematically studying the individual reports of the sub-groups and selecting what appeared to be the most significant statements in regard to policy. Copies of these statements were distributed to all participants during the last three days of the Conference. During the final days, general

sessions were held with greater frequency, lasting for three or four hours. During this time, constant voting and discussion, revision, and amendment of statements took place. Special committees detailed to consider specific problems also presented statements; some resolutions were suggested from the floor. By following a loose parliamentary procedure and providing opportunities for voting along the range from total agreement to total disagreement, approximately seventy propositions were found on which there seemed to be rather general concurrence. (The resolutions will be found scattered throughout this book. Dissenting opinions are presented in the text along with the discussion of many resolutions on which there was little agreement.)

In the week immediately following the meetings at Boulder, five participants presented a symposium on the Conference to about 500 persons at the Denver Convention of the American Psychological Association.

In order to obtain more information about the individual reactions of the 71 participants at the Conference, the executive secretary of the American Psychological Association circulated, a month or so after the close of the Conference, a questionnaire to all who had attended. This information was thought to be particularly valuable since a long general session toward the end of the two weeks had been devoted to a search for some method of continuing group conferences of this sort. This search resulted in a resolution that was unanimously approved:

> It is the sense of this group that it would be desirable for a continuing Conference, short and adjacent to the annual Convention of the American Psychological Association, to be held for discussion and recommendation concerning curriculum problems in clinical psychology. Such a Conference should be open to interested groups, such as the Division of Clinical and Abnormal Psychology, the Division on the Teaching of Psychology, and other groups, including university departments of psychology.

Since conferences of the type held at Boulder are likely to become of increasing importance as the need for closer integration within

the field develops, the organization of this Conference has been presented in some detail.

POST-VIEWS OF THE CONFERENCE

Approximately two months after the close of the Conference, the executive secretary of the American Psychological Association, Dael Wolfle, sent a questionnaire letter to all seventy-one participants asking for their impressions of the meetings. Fifty replies were obtained by the end of January, 1950. Dr. Wolfle's summary of these replies is reproduced below in its entirety.

1. The first of the four questions was, "Knowing what you got out of the Boulder Conference and how much it cost, do you think it was worth while?" Two people said it was not, one was uncertain, and 47 said that it was worth the time, effort, and money that went into the Conference. As a measure of enthusiasm, the answers were separated into those who held the Conference to be worth while and those who thought so with added enthusiasm. Someone else going over the same answers might well disagree with the allocation, but 25 replies fell into the "yes" category and 22 into the "yes with considerable enthusiasm" category.

2. The second question was, "What specific benefits did you get from it?" The most frequent answer was, "Better acquaintance with the clinical training programs being offered elsewhere and with the people responsible for them." Twenty-two specifically mentioned a better acquaintance with other programs of training in clinical psychology; 16 mentioned a better acquaintance with other people in the field and the advantages such improved acquaintance would have for future coordination and exchange of information and ideas.

A good many reported effects upon their own thinking about clinical training. Eighteen said, in one way or another, that it had been a thought-provoking experience and that it had helped to clarify their own ideas. Eleven said that it gave them greater confidence in their own work. Six reported that it shook some of the ideas which they had had before the Conference. Another six were comforted by learning that other people were facing the same problems.

Five reported that they had been able to improve their own courses as a result of the Conference. Three said that the Conference

had allowed them to make a better integration of the work in clinical psychology with psychology as a whole.

Three people did not mention any benefits received from the Conference.

3. The third question was, "Has it changed your own work in any way?" Four did not mention any changes and six said specifically that it had not. Characteristically, these six replies came from people who were not engaged in training clinical psychologists but who were among the others present at the Conference.

Four said that it had changed their own work, but did not specify how. Four said that they were able to do a better job of selecting students. Five reported a clearer notion of the objectives which should be sought in training clinical psychologists.

A number of other answers were quite evenly distributed among several aspects of the whole program. Nine each reported that the Conference had changed the type of instruction being given in courses, the work being offered in practicums, and the training in theory and research being required of students in the program. Ten reported that it had influenced the organization of the training program within the university in its relation to practicum and intern training facilities, or in some other formal fashion.

4. The fourth question was, "Would you recommend trying to arrange another such conference some time in the future? When?" Although one person did not answer the question, no person specifically said that he would not recommend trying to arrange another future conference. There was variation, however, on when such a conference should be held, and there were a variety of suggestions for making a future conference different from the one held in Boulder.

Forty-two said specifically that another conference of essentially the same kind should be held. Four did not say when. The answers of the other 38 were distributed as follows:

1950	3
1951	15
1952	9
1953	6
1954	5

5. The most frequent criticism of the Boulder Conference was the suggestion that future conferences should not attempt to cover so much ground. It was suggested that the conference should be shorter, that fewer problems should be taken up, and that the scope of the

conference should be more limited. The number of agreements to this criticism is unknown, but there seemed to be a fair amount of feeling that the work at Boulder was too ambitious, and that in the future more would probably be accomplished if so many separate problems were not taken up.

There were several suggestions that similar conferences would be desirable for other groups or for other purposes. Four suggested that a similar conference on training at the M.A. level would be desirable. Two suggested similar conferences for industrial or educational psychology. One suggested that a similar conference for the non-accredited schools should be held.

Several suggestions were made concerning the personnel. Four suggested that more varied groups be included in the conference membership. One suggested specifically that there should be more nonclinical psychologists included. One suggested that no medical people should be invited.

One made the suggestion that a future conference should take up subject matter, research, and problems of methodology rather than those of organization.

One person suggested that more preparatory staff work should be done to get people ready for the conference so that it could be held in a shorter period of time.

In general, the expressed attitudes in the replies were highly favorable. Several factors, however, suggest that these replies may have been biased. There were a few criticisms that the discussions were too guarded and that the conference was more set on getting agreement, even at a superficial level, than on getting a thorough discussion of basic issues. Perhaps those facts biased the answers in the favorable direction. Finally, twenty members of the conference group did not reply. Inspection of the names of the nonrespondent did not reveal any systematic factor, but perhaps, on the whole, they were less enthusiastic than those who did reply.

In summary, the attitude of the 50 who replied was highly favorable. Forty-seven of the 50 were certain that the conference was worth while, and feel that they got a variety of benefits from it. It changed the work of most members of the conference in a variety of ways: in research, in practicum and course work, in the organization of training programs, and in ideas concerning the objectives of training and concerning the selection of students for work in clinical psychology. With these attitudes expressed, it is not surprising to find that most members of the Boulder Conference believed that another conference sometime in the future would be

valuable. Although one person wrote that a short conference every year would be desirable and that he would be glad to pay his own expenses to attend it, most felt that 1951 or 1952 would be the best time for a second conference. If such a conference is held, many thought, it would be more valuable if it were less ambitious in scope and did not attempt to cover so wide a range of topics. A number felt that it would be desirable to hold similar conferences for other groups.

THE WRITING OF THE REPORT

Toward the end of the Conference it became apparent that the large number of individual reports on the separate topics would need integration into a more uniform report. The Executive Committee, it was agreed, should continue to serve as an editorial board, since it had been most actively concerned with Conference proceedings over a six-month period. The editor was directed to prepare a preliminary draft to be submitted to the editorial board for suggestions and criticisms during the course of the writing. Material for the chapters was drawn from the sub-group reports of particular topics, from the typescripts obtained from the wire recordings of the general sessions, from the resolutions with their recorded votes, and from various questionnaires distributed during the Conference. Material from the *Bibliography,* which had been prepared in advance by the Executive Committee, was freely drawn upon for background and explanation.

In discussing the final report during the Conference itself, the editorial board decided that issues as well as common agreements on policy should be highlighted wherever possible. Therefore, the preliminary draft, after receiving the general approval of the editorial board, was submitted to all participants in the Conference for their comments and criticisms. With an enlarged reviewing board of 71 persons, it was impossible to record all minority opinions and all suggestions within the compass of available space. Nonetheless, attempts were made to incorporate all significant dissents into the body of particular chapters, especially where the frequency of dissent indicated a sizeable minority opinion. In some instances it was

more practical to indicate dissents or alternative opinions by footnotes.

This book does not follow exactly the order or content of the topics discussed at the Conference. Instead, an attempt has been made to provide a more readable organization, one that would better reflect the actual spirit and particular emphasis given the topics by the Conference discussions. In addition, a final chapter has been written that presents the issues now facing the developing profession of clinical psychology.

Thus the four chapters following this one present the more fundamental matters that the Conference discussed in relation to: (a) the needs of society where clinical psychology is concerned, (b) professional training in a changing society and a changing science, (c) desirable levels of training, and (d) the problems involved in ethical responsibility. The next five chapters, beginning with Chapter 6, cover the more specific problems related to the actual curriculum and its underlying postulates. Beginning with Chapter 11, "Selection and Evaluation of Students," various special issues are discussed which have immediate bearing upon training for clinical psychology but only incidental pertinence to the curriculum.

In the Appendix, in addition to the names of participants, will be found the *1947 Report of the American Psychological Association's Committee on Training in Clinical Psychology* (David Shakow, Chairman). The *1947 Report* was one of the basic documents considered by the Conference. To a very large extent that *Report* had determined the policies underlying the development of university training programs up to the time of this Conference. It was used as the basis for considering whether particular programs should be approved by the American Psychological Association in its recommendations to government agencies and others interested in university training in clinical psychology. The Conference was concerned with major issues of policy and gave very considerable support to the policies that were specifically outlined or implied in the *1947 Report*. The *1947 Report,* therefore, is included, since it presents many details of curriculum organization that could not be covered by 71 persons, even though they met for two weeks of

discussion. It is suggested that readers not familiar with the *1947 Report* will find reference to it advantageous when reading related chapters in this book.

In conclusion, it should be mentioned that this book represents the views of a large number of persons spending a large amount of their time in the training of clinical psychologists. In addition to the participants at Boulder, many members of psychology department staffs have been drawn into the discussions by participants reporting on and circulating the Conference topics, the subgroup reports, and the preliminary draft of the final report. Student and faculty views were solicited by participants in preparing for the Conference. Members of allied professions were present at the Conference and contributed most effectively. Even with this extensive coverage of opinion, many persons actively concerned with clinical psychology and its training programs may have views that are not included here. Nonetheless, it is felt that this report does represent a fairly adequate cross-sectional view of the agreements and unsettled issues in the training of clinical psychologists. It is hoped that its influence will be felt largely as a means of informing psychologists, as well as members of allied professions and other persons interested in this field, of the current trends in training, so that concrete practices can be subjected to closer scrutiny and basic policies can be reviewed.

CHAPTER 2

Social Needs and Clinical Psychology

It has often been pointed out that a profession is distinguished from other occupational groups by reason of its "service" aspects. Thus in one sense, any profession that is committed to serving social needs is an instrument of society. The influence of society does not end here. In a still broader sense, social needs to a large extent determine the directions in which any profession will grow. Clinical psychology in recent years is an excellent example of the interaction of a professional group and social needs. As was pointed out in Chapter 1, the recent professional developments in clinical psychology were largely war-instigated, and following World War II were compounded by recognition of the need for more and better-trained persons to minister to the mentally and emotionally disturbed.

Although social pressures are of great importance in fostering professional growth, they are not completely determinative. The policies of a particular professional group can also serve to guide its destiny. If such policies are in line with the over-all needs of society, both survival values for the profession and greater services to society can be expected. If the early policies are not helpful in solving social demands, stagnation or withering away can be anticipated. As a fairly young profession, clinical psychology is in both an enviable and a precarious position. There is no doubt about the immense, unmet social need for more and better mental hygiene services, including research. The task before clinical psychologists, at the present time, lies in adopting such policies in their training institutions as are best calculated to provide services that can demonstrate social usefulness.

This was the immediate background against which the discussion of policies in the training of clinical psychologists took place. Much of the necessary ground had been covered in the literature of recent years. Statistics on the incidence of gross mental disorder can be found in any textbook of psychiatry or abnormal psychology or in the many pamphlets and leaflets widely distributed by various groups interested in mental health. The need for immediate diagnostic and treatment services had been recently underscored by the large number of budgeted but unfilled positions open to members of the mental hygiene professions. As a direct result of public education over the past thirty years in problems of mental health, there has been an important change in the attitude of society toward large groups of people formerly regarded as hopeless outcasts, such as psychotics, delinquents, and even the mentally deficient. Treatment and retraining of these persons are now generally expected by the public, whereas in previous years interest had centered largely in diagnosis and custodial care. Of perhaps greater importance than any of the above has been the persistent belief, which is still little more than a hope, that preventive measures can be found that will radically reduce the number of the maladjusted and mentally ill.

As a result of such discussions, the Conference approved a formal resolution outlining more concretely the social needs that can be served, to some extent, by trained clinical psychologists. It reads:

> The basic needs of our society for the services of clinical psychologists are of two major kinds:
>
> a. Professional services to:
>
> (1) Individuals through corrective and remedial work as well as diagnostic and therapeutic practices
>
> (2) Groups and social institutions needing positive mental hygiene programs in the interest of better community health
>
> (3) Students in training, members of other professions, and the public through systematic education and the general dissemination of information
>
> b. Research contributions designed to:
>
> (1) Develop better understanding of human behavior

(2) Improve the accuracy and reliability of diagnostic procedures
(3) Develop more efficient methods of treatment
(4) Develop methods of promoting mental hygiene and preventing maladjustment

It should be noted that the services included in the list above are designed to meet three primary objectives: (1) they are intended to provide immediate help for persons in need of professional psychological assistance; (2) they serve the ultimate social goal of preventing the development of conditions requiring treatment; and (3) they are intended to contribute to the development of a concept of positive mental health in which emphasis is on maximum development of individual potentialities rather than on barely adequate adjustment.

The Distinctive Activities of Clinical Psychologists. In meeting the social needs outlined in the resolution, clinical psychologists perform certain functions that overlap considerably with those of professional persons in other areas of psychology and in other mental hygiene fields. The concept of the "mental health team" has undergone some changes from its original notion of a group of specialists with characteristic and nonoverlapping functions. At the present time, the team setting seems to provide optimum conditions for most training and practice, but establishment of teams in practical situations is not always feasible. Where a clinical psychologist is working alone, it is imperative that he be sufficiently well trained to be aware of his own limitations, to know what the other professions can contribute, and to recognize the situations requiring referral or consultation.

There are, however, some fairly distinctive activities in which clinical psychologists engage and for which they can be trained. Of perhaps first importance is the traditional concern of the psychologist with the discovery of knowledge about behavior and personality, by means of systematic research and critical analysis of attempted explanations in terms of the available data. Psychologists are trained in the devising of methods and the carrying out of

studies that make available for confirmation or denial the private experiences and judgments of individual clinicians. Publicly tested knowledge must in the end constitute the basis for sound psychological applications.

One imperative need in this regard is for the derivation and establishment of principles about the nature of psychotherapy; another need is for the selection and evaluation of proper techniques for modifying personality. In the area of psychodiagnosis, clinical psychologists have developed as their own particular province the use of a wide variety of standardized evaluative techniques, emphasizing particularly objective and quantitative measures.

In the improvement of community mental health, clinical psychologists, together with members of other interested professional and nonprofessional groups, can assume, and occasionally have assumed, responsibility for improving mental health conditions. Much more effort needs to be expended along these lines.

Implications for Training. In view of the foregoing, it seems obvious that graduate students in clinical psychology will need training in the current clinical techniques of psychology, including psychometric and psychodiagnostic methods. In addition, they should receive some training in psychotherapy.

While there should be a common core of training in clinical psychology, it is not assumed that all clinical psychologists should be trained fully in every clinical area. A certain degree of specialization is necessitated by the extensive scope of the field.

Since it is anticipated that many clinical psychologists will have some responsibility for community mental health, and since they will also obtain employment in social institutions, their training should include work in social psychology, group dynamics, and related areas.

Research Training. In addition to the training mentioned above, the Conference felt that all clinical psychologists should receive a research orientation in their graduate training. There are two reasons for this: first, the primary functions of some clinical psychologists will be the execution and direction of research; second, those clinical psychologists primarily engaged in service activities

must be able to evaluate the development and assessment of new diagnostic, therapeutic, and preventive techniques. Similarly, all clinical psychologists require training in general psychology in order to apply to their problems a background of knowledge and critical thinking about basic factors in human behavior.

Although research training is discussed in more detail in Chapter 8, it should be pointed out here that the Conference made an important decision when it recommended that research be given a place of equal and coordinate importance with practice in the education of graduate students in the clinical area. Such a decision was not reached without considerable discussion, questioning, and initially divergent opinions. There was much honest doubt whether all graduate students could be trained in both areas. Such doubts and questionings continued, for many, throughout most of the Conference. At the end, however, the original chasm seemed to have largely disappeared, and recognition of the importance of including research training in the preparation of all clinical psychologists was generally accepted.

CHAPTER 3

Professional Training in the Light of a Changing Science and Society

Participants at the Conference were acutely aware that the formulation of training policies is a task that requires analysis of the needs of many segments of society as well as analysis of the over-all public need itself. In addition to the various clinical and age groups for whom the services of clinical psychologists are intended—such as behavior problem children, the aging, and the mentally disturbed—there also must be considered the professional needs of the graduate students undergoing training and of the members of allied professions. Furthermore, the events of the past decade that had brought such marked changes to clinical psychology served to emphasize the fact that the policies of today might well be out of date by tomorrow.

In one sense, the decision to train students broadly in clinical psychology so that their training will include clinical practice with all age groups, and in addition to train them in general psychology and in research methods, represents in itself something of a safeguard against the intensive cultivation of a small area of contemporary social need that might rapidly become insignificant as society and the allied professions undergo changes. For this reason, one of the most frequent comments at the Boulder Conference was that training in clinical psychology should be broadly professional in the doctoral program, leaving most specialization to post-doctoral experience.

The previous chapter discussed the views of the Conference in regard to the relation between clinical psychology and the needs of

society. The next section of the present chapter discusses the very likely possibility that changes will take place within clinical psychology. The final section of this chapter is devoted to various methods for insuring that when changes occur, in either social need or psychology itself, these changes will be recognized and incorporated into training programs.

THE VALIDITY OF PRESENT ASSUMPTIONS IN CLINICAL PSYCHOLOGY

Early in the Conference it was felt that some attention should be given to a survey of participants' opinions on the validity of current techniques in clinical psychology. Two extreme viewpoints are most likely to be elicited by such a survey: condemnation of the techniques as being poor, and therefore invalid; or acclamation of them as having demonstrated their usefulness, and as therefore being valid. Accepting either of the extreme viewpoints is probably a matter of individual optimism or pessimism motivated by the purposes one has in mind in making definitive statements. As in any other effort to reach an inclusive generalization, marked inaccuracies are very likely to become intermingled with adequate statements. The validity of the techniques of clinical psychology obviously can be considered only in terms of particular techniques used for specified purposes. Final decisions on the "validity" of a tool or a technique depend ultimately upon objective evidence. Yet at some point in the process, subjective opinions have demonstrable value, if only to chart the next logical steps in finding out how "good" one's present tools may be.

This was the spirit behind the discussions relating to the validity of present techniques in clinical psychology. That our techniques have considerable value must be regarded as an unstated accompaniment to the remainder of this chapter. The Conference would not have been called if this assumption were untenable. Since, however, a discussion of the validity and usefulness of techniques in an admittedly developing field is inevitably oriented toward finding weaknesses and places for desirable improvements, it is only to be

expected that unflattering evaluations are likely to predominate. Furthermore, in the field of clinical psychology we have special reasons to be concerned with the validity of the assumptions underlying the techniques in daily use. All the mental health professions are in a similar position of being forced to use whatever techniques *seem* to be effective, since human welfare does not permit the considerable periods of time necessary to evaluate thoroughly those methods devised for diagnosis or treatment in the mental health area. Nor should it be overlooked that research in human personality represents one of the most difficult areas of scientific endeavor, as gauged by the present rash of untested theory in psychology, clinical psychology, psychiatry, and social work.

The urgent needs for service have sometimes forced the psychological worker to use inadequately tested tools and techniques. The war and postwar requests for service faced the clinical psychologist with many new demands for which he was only partially equipped. Since no other discipline seemed to be any better equipped for certain types of work in this field, the clinical psychologist usually accepted the responsibility of trying to do what he was asked.

The following report from a special committee appointed to consider the "validity of present assumptions" furnishes some of the tenor of discussions on this topic.

> Social needs, demands for service, and our own desire to serve effectively have compelled us to engage in programs of action before their validity could be adequately demonstrated. We have, perforce, used tools in need of sharpening, and relied on intuition in lieu of data. We have accepted assumptions, sometimes uncritically, sometimes skeptically, and sometimes for the time being only or as "best available knowledge."
>
> We are assuming, most broadly perhaps, that we are of service. We are assuming that we do know something about human behavior and its betterment, that our instruments and techniques are relevant and effective, that our training procedures enhance the competence and sensitivity of our successors, and that new knowledge of importance emerges from our research. We believe that many of these and other assumptions can be validated.

We accept assumptions of this order without apology. While we believe in what we are doing, we also accept the responsibilities it entails. At the same time we accept an obligation to evaluate our work and ourselves. We accept it as an obligation in some sense peculiar to clinical psychology, implicit in our role of clinician among scientists and scientist among clinicians.

Examining the validation task before us, this Conference finds encouragement in the progress we have made through the years—but it is chiefly impressed by the work that is still to be done.

We recognize the difficulties inherent in bringing scientific methods to bear upon living people, particularly upon the scientist himself, in validating method and criterion against each other simultaneously, and in measuring status in the midst of change and change from uncertain base lines of status. We recognize subtle conflicts between the therapeutic attitude and impartial objectivity. We are, nonetheless, determined, as a profession, to face the validation issue squarely. We challenge ourselves to make our predictions more explicit, and to subject them to rigorous verification tests, to deal with the socially significant, tangible problems of concern to the lay community, to fit theory to facts, methodology to function.

A summary of the Conference's attitudes toward the validity of our present techniques was approved, without a dissenting vote, in the form of the following resolution:

While the clinical psychologist has faith in the value of his service efforts, he is increasingly concerned with the improvement of the scientific status of his profession through meeting the needs for validation in the following areas.

(1) Personality theories
(2) Research methodology and validity criteria
(3) Training procedures
(4) The clinical psychologist himself as a participant observer and professional practitioner
(5) The instruments and techniques used in clinical practice.

Personality Theory. Although some participants may have come to the Conference prepared to do battle for or against certain specific techniques, the discussion during the opening days revealed such unanimity of opinion about the primary task of the clinical psychologist that what had been thought of as major battles turned

out to be minor skirmishes. The discussion of technique validity pointed to one rather simple fact: only when there is general agreement on the major principles of personality organization will the problem of evaluating techniques designed to assess personality manifestations or to change personality functioning be much nearer solution. Without an underlying theoretical framework, the evaluation of a particular technique becomes an almost hopeless task of trying to decide whether one observer's opinion is any better than that of another. Observable data, in the form of objective behavior or even verbal report, form the only basis for progress in scientific psychology. Deciding what observable data to select for analysis constitutes the great contribution to be made by personality theory.

The Criterion. As in many previous meetings and in countless published articles, the problem of finding suitable criteria against which test or treatment results can be gauged was a major topic of lament. One sub-group reported, "The unavailability of good criterion indices and measurements constitutes a major obstacle to the validation of our techniques and theories. Ratings, clinical diagnoses, and the like, which commonly serve as criteria, leave much to be desired. Behavioral events seem to hold the greatest promise as dependable and meaningful criteria." This statement was obviously directed against the acceptance of "expert judgment" as a criterion for deciding whether, for example, a group of subjects actually were particular kinds of schizophrenics, whether particular patients under treatment had actually improved, and so forth. Who is mentally healthy and who is not mentally healthy also seems to be a problem in urgent need of solution.

Economics and Cooperative Research. Throughout every discussion of research in clinical psychology arose an insistent complaint over the sheer expense of assembling sufficient personnel, subjects, and time to make a thorough study of a given problem. Fragmented research seems to be uncomfortably characteristic of our present literature. New techniques or hypotheses spring into existence with impressive supporting theory or significant differences between groups, only to shrink into question marks after the passage of a number of years. Such developments are undoubtedly characteristic

of scientific progress, but need not always be tasted to the dregs.

One possible solution is to encourage particular individuals to devote their lives to small areas in the hope that time will substitute for numbers; but many of the problems of psychology and psychiatry should not wait a lifetime for solution, although many undoubtedly will. Another solution, which has received much support in the physical sciences (atomic development) and the biological sciences (cancer research), lies in the possibility of cooperative investigation on a national or regional scale. Clinical psychology and psychiatry are badly in need of many extended investigations into the validity of their constructs in personality theory and the usefulness of their diagnostic and therapeutic techniques.

Unanimously, therefore, the Conference approved the following resolution:

> This Conference approves national planning and cooperative group research among universities and other institutions on the evaluation of clinical techniques and personality constructs. Such investigations can often be carried on most effectively by large-scale carefully integrated program planning.

Implementation of this resolution must, of necessity, wait upon the efforts of individuals or small groups to provide significant and convincing research programs that can be widely endorsed and for which financial support can be secured. Since large-scale cooperative investigations seem at present to represent one of the most effective methods for securing badly needed research data, this resolution in reality presents a challenge to individuals in the research field to devise plans that will call forth the necessary support. The implication for training is obvious. Universities should rather encourage students to consider the possibilities of cooperative research than insist upon the creative insights of the individual psychologist as the only method for conducting research investigations.

In summary, it seems that the Conference was quite willing to go on record as believing that our tools and techniques are badly in need of validation despite the fact that they serve some useful pur-

poses at the present time. In the field of psychotherapy, validation of present techniques and development of more effective ones constitute two of the most pressing problems. It may well be that research designed to clarify principles of personality organization will be more effective for providing solutions to present problems of technique than will research in any other area.

DIVERSITY VERSUS UNIFORMITY

It has been previously pointed out that the Conference deliberately decided to emphasize the importance of broad, fundamental training in the doctoral program as one means of insuring that clinical psychologists will have an opportunity to develop a professional *field* rather than a narrow specialty. An emphasis upon diversity can also help to prevent the professional stagnation that may result from a highly uniform training program so set in a particular orientation that the profession remains unresponsive to new or changed social and professional needs.

This interest in diversity does not mean that the Conference failed to reach any agreement on a basic minimum of training in clinical psychology. The following resolution was prepared to express the view of the Conference in this respect:

> The graduate education of all clinical psychologists should involve thorough and intensive work in four areas:
> (1) General psychology, which includes such subjects as systematic, experimental, and social psychology
> (2) Clinical psychology and mental hygiene, which include broad training in theory, method, and techniques
> (3) Field work with a variety of clinical problems at different levels of responsibility
> (4) Research and methods of investigation.
>
> Beyond these core areas, each department should provide additional education in accordance with its distinctive facilities and objectives. The resources of each university should be so integrated and used as to provide that diversity of methods and objectives which will insure the continued possibility of experimentation with new methods of education to the end that quality and vitality are not sacrificed for uniformity.

Such a policy of encouraging diversity of training might well be undetermined or blocked by accrediting bodies that insist upon uniformity as a short-sighted means of achieving immediate goals at the expense of more important, long-range objectives. Although the accrediting body for clinical training programs has itself been urging a policy of diversity, the Conference thought that future committees might change their thinking in this respect. Realizing that a policy of diversity should be fostered at all levels in order to insure its acceptance, the Conference adopted the following resolution, which was forwarded to the American Psychological Association at its Denver meeting in September, 1949:

> We urge the creation of a committee with broad powers to examine and review educational philosophy, methods, and standards beyond those serving as the foundation for accreditation in any one field of applied psychology, and with the power to review accreditation policies and practices. (Further discussion of accreditation will be found in Chapter 15.)

The Pros and Cons of Uniform Training Programs. Although the Conference endorsed a policy of diversity in training programs, it also agreed upon a minimum core of common training. The following advantages and disadvantages of a uniform educational program were considered.

In some ways, highly uniform training provides protection to the public in that the title "clinical psychologist" then comes to have a very definite meaning. Such protection may be illusory, however, in view of the fact that insistence upon uniformity may sacrifice the advantages to the public that may be gained more effectively by keeping the profession constantly aware of long-range objectives than by trying to satisfy immediate goals. Furthermore, employing agencies and institutions are well aware that most professional training attracts students with widely divergent goals and backgrounds so that selection of professional employees becomes a matter of selecting individuals with particular qualifications rather than of selecting employees because of the titles they bear. The inclusion of a common core of training should help to identify broadly those

persons who have been trained as "clinical psychologists"; but not all clinical psychologists will have identical interests and competencies, any more than all lawyers are alike because they have the same degree and have passed similar examinations.

A highly uniform training would also make for easier relationships between clinical psychologists and members of allied professions, with whom clinical psychologists are in constant contact. Here again, the same counter-arguments seem to be valid. No one expects all persons called psychiatrists or psychiatric social workers to bear the same stamp. Differences in interest and area of activity are positive assets in those professions. Different persons with the same title cover broad fields of work in improving mental health, from children to the aged, and from minor maladjustments to serious psychoses. It was felt that the needs of the other professions will best be served if clinical psychology likewise supports a policy that trains persons for many types of clinical psychology rather than for one narrow specialty.

One of the most regrettable aspects of diversified training programs lies in the difficulty that arises when a student transfers from one institution to another. Time is almost inevitably lost in such transfers. Since, however, the number of transfers is very small, and likely to become even smaller as admission to clinical training programs becomes more difficult to obtain, little action was taken on this problem. There are sometimes distinct advantages to students in being able to transfer from one university to another in order to study with staff members known for a particular specialty. Such cross-fertilization has been encouraged in the past. Its advantages may still be utilized in some instances by having students attend other universities for a semester or even a full year without transferring for completion of the degree.

Mention should also be made of two further points that were influential in the thinking of Conference participants. First, in its present stage of development, training in clinical psychology cannot afford to become crystallized. Second, a too uniform development is often conducive to compliance in the accepting of educational

goals and methods, rather than to the use of individual initiative in the working out of more desirable programs.

In summary, the Conference felt that training programs for clinical psychologists must reflect the changing needs of society as well as the theoretical and technical changes taking place within the profession of psychology and its related fields. It was agreed that in view of the wide gaps in our present knowledge, the validation of our working assumptions is a task of the utmost importance. In addition to research carried out by individuals, group or cooperative research would help in arriving more quickly at answers to pressing problems of human welfare. In order to keep the profession sensitive to changes in society and in psychology, diversified university training programs should be encouraged, although a basic core of general and clinical psychology will be necessary to provide a certain amount of uniform background.

CHAPTER 4

Kinds and Levels of Training

The amount of training that should be required of workers in the mental health professions constitutes a particularly difficult problem. Safeguarding and promoting an individual's mental welfare is a challenging task, even when the best-trained workers and the most elaborate techniques are brought to bear. Mistakes of diagnosis and treatment may perpetuate themselves over many years, not only affecting the client or patient but also spreading out to involve entire families. Even the best-trained workers may misinterpret an interview or a test, and as a result apply a false label or initiate expensive and possibly harmful treatment procedures. Although issues of life and death are only occasionally faced in work of this sort, undetected suicidal trends or organic illnesses masked by neurotic symptoms are disquieting risks well known to all workers in this field.

Examples of errors in diagnosis that have resulted in years of tragedy could be cited almost indefinitely, even where such supposedly simple matters are concerned as the administration and interpretation of an individual intelligence test like the Stanford-Binet or the Wechsler-Bellevue. Most clinical psychologists have encountered many cases of children mistakenly diagnosed as mentally deficient on the basis of tests used by improperly trained people. The Rorschach test, with its even less well understood interpretation and its inadequate standardization as regards normals, is particularly susceptible to misuse in the hands of the poorly qualified but enthusiastic worker. And these tests are but some of the simpler techniques used by clinical psychologists.

The profession of medicine does not always provide a good parallel for estimating problems in clinical psychology. Nonetheless, in those fields of medicine where the scientific systematization and understanding of techniques is far advanced over those of psychology or psychiatry, general policies have long forbidden even such simple "tests" as the taking of blood pressure to be interpreted by persons lacking the full allotment of professional training. To some extent, of course, the risks run in the mental hygiene field are somewhat less than those in general medicine; for in the former field acute crises involving much suffering and a possibly fatal outcome are encountered much less frequently, and ordinarily there is a long period of prodromal symptoms before a crisis occurs. In a large number of cases of maladjustment or neurosis, an acute crisis may never occur and real dangers are averted by natural processes.

One other aspect of the general situation in which the mental health professions operate must be considered. Much of their work falls within the realm of "public welfare," since only a very small proportion of the delinquent, the maladjusted, the neurotic, and the psychotic can afford the expense of private care. Public welfare activities depend upon budgets that are too often the leftovers after the bulk of public money has been appropriated for other departments.

As a result of the chronic shortage of funds in the welfare field, agencies and institutions are often faced with the dilemma of employing well trained workers whom they cannot afford or adding to their staffs persons who are less well trained but know some useful techniques.

This combination of circumstances, which demands that workers in the mental health professions obtain many years of costly training in order to avoid making even supposedly "simple" mistakes, coupled with the very great demands for these services at salaries that are sometimes absurdly low, is a problem faced in common by psychiatry, social work, and clinical psychology.

The concrete question is this: What kinds of workers should be trained in the field of clinical psychology? Should our efforts be

devoted entirely to preparing people at the Ph.D. level? Or is it desirable to consider other levels of competence? Academic tradition has left us with two levels, the Ph.D. and the M.A. To some extent, these two levels have been perpetuated in the nonacademic world, in that government agencies recognize both levels in their various civil service classifications, and there are large numbers of persons with one or the other degree employed in institutions and agencies. A few of each are at present engaged in private practice.

The Conference considered four possible levels of training. These were (1) the Ph.D. in Clinical Psychology with supervised post-doctoral training; (2) the Ph.D. in Clinical Psychology with four years in a graduate school of which one year is a supervised internship; (3) sub-doctoral training of approximately two years with or without the M.A. degree; (4) the B.A. degree without graduate training. In actuality, the discussion was concerned almost entirely with the second and third levels since it was recognized early that post-doctoral training is a problem for the future (it is discussed at greater length in Chapter 17); and the B.A. degree program as presently constituted is suitable only for pre-professional training.

The B.A. Degree. Before discussing the Ph.D. versus sub-doctoral training, it should be noted that Conference members reported that there is now widespread recognition that the B.A. degree with a major in psychology carries with it no vocational competence in professional psychology. Technique courses at the undergraduate level are being abandoned (as they should be), although many courses in individual intelligence and personality tests still remain in various curricula. Apparently there is still some need to inform undergraduate majors of the need for graduate preparation if they are considering psychology as a career. A few employers also mistakenly assume that a person with a B.A. degree and an undergraduate course in "mental tests" is a bona fide clinical psychologist. Although the national picture from this standpoint is encouraging, the Conference accepted as one of its most important problems the attempt to define the term "clinical psychologist."

DEFINING "CLINICAL PSYCHOLOGIST"

There is little doubt that applied psychology in the clinical area is as yet a specialty that is but little understood in the public mind. This is not surprising in view of the short history and relatively small membership of the profession at the present time. The educational task of the psychological profession is not confined to work with the general public, since many members of such allied professions as medicine and social work may never have worked with clinical psychologists or may mistakenly regard the psychometrist, who is narrowly trained in the administration of tests, as a representative member of the profession. Mistaken notions in another direction may also occur since, as was recently pointed out by Dr. William Menninger:* "Many physicians, as well as laymen, simply do not have sufficient knowledge to distinguish between a psychiatrist and a psychologist."

To obtain uniformity in terminology and to present the public and allied professions with a definition of persons qualified to do independent professional work in this field, the Conference recommended (with only one dissenting vote) that:

> The title "clinical psychologist" should be used only by persons who have received the doctoral degree based upon graduate education in Clinical Psychology received from a recognized university.

The Conference also agreed that if this recommendation is generally accepted, specific exceptions should be made for well qualified persons who are now recognized by the profession as competent in this field, but who may not have received a doctoral degree. (The so-called "grandfather clause" is a common procedure for avoiding injustices when new regulations or new definitions are introduced into professional practices.)

The phrase "doctoral degree" was purposely included in the above resolution rather than the more specific "Ph.D." because Federal Civil Service and other agencies recognize other degrees as

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* "The Relationship of Clinical Psychology and Pschiatry," *American Psychologist,* 1950, 5, 13.

the equivalent of the Ph.D. Some concern was expressed that such a substitution, if used indiscriminately, might enable persons with other degrees but with little actual training in clinical psychology to use the title without warrant. Much of this concern was reduced when it was pointed out that the recommendation expressed in the above resolution is a statement of general policy rather than a certifying or licensing regulation.

It would perhaps be difficult to defend the proposed definition for the clinical psychologist were not present practices so generally in accord with its intent. It was pointed out at the Conference that almost all university departments feel strongly that a "psychologist" is first of all a person with the Ph.D. Persons trained to sub-professional levels may be called psychologists by various employers, but this application is usually intended to describe the type of work engaged in rather than as a means of identifying competence. Furthermore, Federal Civil Service job descriptions are tending to limit the appellation "clinical psychologist" more and more to those with doctoral degrees. The Veterans Administration hopes to restrict the title at some future date to persons with the Ph.D., much as the title "physician" is applied only to persons with the M.D. degree.

One of the strongest arguments for restricting the use of the term to those persons who fall within the definition given in the resolution lies in the current confusion over who is a clinical psychologist. In many places the term is applied indiscriminately to those who do nothing but give intelligence tests (properly called "psychometricians"), or to persons who are capable of carrying out a good portion of the professional duties as currently envisaged but who lack complete training, as well as to persons with adequate background and competence in most areas of clinical psychology. This situation has led to great confusion on the part of employers who want to hire a clinical psychologist but who cannot find a ready means for identifying those who are capable of performing the duties. Certification at the diplomate level by the American Board of Examiners in Professional Psychology does little to help the immediate situation, since such certification is at the highest level

and automatically omits many persons well qualified to work in the applied clinical area.

While the Conference was aware that limiting the title "clinical psychologist" to those with doctoral degrees and adequate training from a recognized university may do an injustice to some persons, there was a strong feeling that such a step will in the end safeguard the public as well as the profession against the still greater evils that are bound to arise if the profession can not define what the title "clinical psychologist" stands for.

The Conference was called by the American Psychological Association as a conference rather than a legislative body. Its recommendations are, therefore, not binding upon anyone in or out of the profession. Nonetheless, it is hoped that the decision of the Conference to limit the title "clinical psychologist" will be generally recognized by other psychologists, educational institutions, the allied professions, and employers as a logical step designed to protect the public and to create some order out of the present confusion. Full recognition of the present recommendation will depend, of course, upon the inclusion of its intent in laws and regulations drawn up by licensing or certifying bodies.

SUB-DOCTORAL TRAINING

Any discussion of training programs for persons at sub-doctoral levels should properly be included in Chapter 17 of this book. The topic is one that involves many persons in and out of the American Psychological Association. It is complicated by the present and probably continuing demand for persons with some psychological training to work at sub-professional salaries. It is a topic that also affects other professional groups within the American Psychological Association, such as industrial psychologists, counselors, and school psychologists. It inevitably creates many knotty problems for groups considering licensing or certification procedure. A committee of the American Psychological Association is now engaged in studying the problem.

Many universities presently engaged in training students at the

sub-doctoral level were not represented at the Conference. Despite this omission, much discussion was held on the topic of sub-doctoral training, since it is intimately related to the problem of definition of the field of clinical psychology. The final conclusions of the Conference in regard to this topic can best be summed up in the following resolution, which was transmitted to the Board of Directors of the American Psychological Association at its Denver meeting in September, 1949:

> The members of the Boulder Conference agreed on the need for strict maintenance of training programs in clinical psychology at the doctoral level, and recommend that for future entrants into the field the term "clinical psychologist" be reserved for persons who have received the doctoral degree based upon graduate education in clinical psychology at a recognized university.
>
> The members of the Conference gave serious consideration to the functions in the field of clinical psychology of individuals with other than doctoral training, and resolved that it is reasonably probable, on the basis of present evidence, that specific procedures which contribute to professional psychological services can be carried out by well trained psychological assistants whose training is at less than the doctoral level and whose work in the field of clinical psychology is ordinarily supervised by a clinical psychologist.
>
> Further, the Conference members recognized that definition of the training and functions of such persons was outside the immediate scope of the Conference, which had neither the basic data nor the comprehensive representation to deal with these questions.
>
> It recommends that the American Psychological Association, through appropriate channels, make a study of:
>
> (1) The proper functions and titles of such persons with other than doctoral training in clinical psychology, and
>
> (2) The extent of the relative and absolute needs for psychologists and for such assistants.

A number of other resolutions were considered but were finally deleted by Conference action in order to avoid prejudging the results of the recommended survey. The discussion that accompanied the deleted resolutions is reported below:

A large number of terms have been suggested at various times for designating persons who have training that does not meet the

requirements described above for the clinical psychologist. A few of these titles have been in use in restricted areas. There are widespread objections to most of those suggested, especially those which presumably carry the implication of "mere technician." Therefore, "psychotechnician" and "psychological technician" have generally been poorly received. "Assistant clinical psychologist" and "assistant psychologist" have been rejected for much the same reasons, although these terms have been additionally disapproved because of the implication they carry of apprenticeship training. The Conference agreed that sub-doctoral levels of training should be organized as distinct programs for specific kinds of work rather than as steps on the road to the Ph.D. in clinical psychology. "Psychological service worker" was suggested as a title at the Conference and seemed to receive some approval, although there was considerable objection to its lack of specificity in regard to clinical psychological services. It is likely that other areas of psychology will also continue to train at sub-doctoral levels, and that terms will be needed to differentiate one kind of training from another. Acceptable terminology for such workers was not settled upon at the Conference, and the problem will undoubtedly call for further discussion.

One point that led to much confused discussion refers to the relationship between training programs for the Ph.D. and sub-doctoral levels. It was proposed that students who fail to complete the doctoral degree should not be awarded a certificate or degree representing a sub-doctoral level of training. This suggestion grew out of the feeling that sub-doctoral programs should be different from the Ph.D. programs. Objection to this point of view was based upon the argument that many graduate students failing to complete doctoral dissertations in clinical psychology are as well trained as students who complete a terminal master's degree. The conflict was to some extent reduced when it was pointed out that the sub-doctoral training programs contemplated are not necessarily abbreviated doctoral training programs, and that they probably will include subject matter and training procedures that are not duplicated in the doctoral training programs. Although this solution

seemed relatively satisfactory at the time, it is obvious that its reasonableness will hinge upon the programs actually worked out and put into effect at sub-doctoral levels. Graduate courses that duplicate each other are generally accepted as substitutes. Therefore, the awarding of a degree or certificate different from the one originally intended by the candidate will depend upon the specific requirements of each program. Finally, there was approval of the principle that students disqualified from continuance of training in the doctoral program because of personality defects or for ethical reasons should not be considered as good candidates for the sub-doctoral degree or program.

It was also suggested that persons who successfully complete work at the sub-professional level might well wish to be considered as candidates for the Ph.D. in clinical psychology. It was pointed out that such persons could apply for admission as candidates and have their qualifications judged on the basis of proficiency and competence along with other applicants.

Several other suggestions that were made are recorded here for the use of any committee studying the problem. It was proposed that training at sub-doctoral levels should be undertaken by appropriate university departments rather than by special professional schools. It was also suggested that those universities engaged in training at the doctoral level need not feel called upon to train at sub-doctoral levels, since there are many universities with adequate programs at the sub-doctoral level that have no interest in developing doctoral training programs.

The technical nature of the programs contemplated for sub-doctoral levels was emphasized by the acceptance accorded the suggestion that a certificate for such training need not involve the M.A. degree. The use of such a certificate at the Ph.D. level was briefly discussed, since the University of Chicago awards a certificate in clinical competence to persons also receiving the Ph.D. degree. The Conference felt that there has been too little experience with certificates to warrant recommendations at this time.

The thinking of a large proportion of the Conference in regard to some features of a training program at sub-doctoral levels is found

in the report of one sub-group that explored the matter rather thoroughly. A section of their report is reproduced here as being representative of Conference thinking, although it did not carry the approval of the Conference as a whole:

> The group agreed unanimously that immediate and serious consideration should be given to the problem of establishing a sub-doctoral training program of at least two years' duration. This program, which would be terminal in nature, should not be composed of the first two years of present Ph.D. training, but should be designed specifically for the purpose of training workers to handle the technical routine and service functions of clinical psychology. In addition to regular academic courses, this program should include supervised field experience. The program must be organized so that students will select it as a desirable service goal in view of its status and service possibilities. Applicants should be carefully selected for this level of training so that it does not become a job solution for those who fail to reach the doctoral level. Individuals granted this degree should be certified as to their level of accomplishment as well as to their area or areas of competence.

CHAPTER 5

Professional Ethics and Problems of Training

The Conference paid particular attention to the topic of professional ethics. In a profession rapidly admitting large numbers of newly trained members, and with constantly increasing public responsibilities, there was early agreement that

> Departments of psychology have the obligation to include in their graduate programs in clinical psychology information regarding professional responsibilities and ethical problems peculiar to the different areas of clinical practice as well as to inculcate the highest ethical principles among their staffs and students.

The unanimous agreement to this proposition was overshadowed, however, by the practical problems now facing all clinical psychologists where ethical practices are concerned. A conference on training is obviously not the place to settle an issue that affects all members of a profession. Nonetheless, it was felt keenly that the present large-scale training of new members presents an urgent necessity for the formulation of ethical standards appropriate to the specific problems and traditions of clinical psychology.

A resolution to this effect, formally approved in general session, was transmitted to the American Psychological Association, at its Denver meeting, as follows:

> The members of the 1949 Conference at Boulder wish to convey to the Council of Representatives their appreciation of the work of the Committee on Ethical Standards, and further, in recognition of the urgent and immediate need of an ethical guide for the practice of clinical psychology and for use in the instruction of students in

clinical psychology, request that the Council of Representatives instruct the Committee on Ethical Standards to give early priority among its several tasks to the formulation and distribution of that section of the guide dealing with the practice of clinical psychology.

ETHICAL PROBLEMS IN CLINICAL PSYCHOLOGY

Although no attempt was made to devise a code of ethics, much time was spent examining the ethical problems of the clinical psychologist. There was general agreement that loyalty to the individual client or patient should constitute a general guiding principle in professional practice. Yet there was also clear recognition that each clinical psychologist must be aware of the needs and rights of society at large, including even those clients or patients who are not his immediate or personal concern. The protection of many other patients or clients may well be involved in safeguarding the welfare of a particular person. The reality of such multiple loyalties is most clearly seen in the practice followed in an institution such as a hospital or clinic, where efforts are directed toward the welfare of a large number of persons. If unswerving devotion to the needs of a particular patient leads to embarrassment or negation of the purposes of the institution itself, many patients will suffer. Thus the primary loyalty of the clinician to the individual may be superseded by concern for the welfare of the group when either legislation or well-known and established practice requires that the interests of the group be protected.

Problems relating to the rights of the individual versus the welfare of the group are not peculiar to clinical psychology or even to the mental health professions. They do, however, serve to increase the complexity of practical situations. Whereas the general principle of loyalty to the individual is accepted, the psychologist must also be aware of his multiple responsibilities. One sub-group of the Conference reported seven areas in which the clinical psychologist has ethical obligations. After the first, there was no attempt to rank them in order of importance.

1. To clients or patients
2. To the general public or society
3. To science
4. To employers
5. To one's own profession
6. To related professions
7. To students

Although it was recognized that there are reasons to protect the members of one's own profession in order to safeguard the welfare of patients in contact with other clinical psychologists, there was unanimous agreement that this need should not be used as a means for protecting individuals known to be irresponsible in practice. The physicians in attendance at the Conference pointed out that medical societies have to some extent solved this problem by exercising very strict internal discipline. At the present time, disciplinary action is more difficult in clinical psychology; but with widespread efforts being made toward certification and licensure, possibilities for such internal controls will increase.

Methods for Insuring Ethical Practice. Although a code of ethics was felt to be a necessary guide to ethical standards of practice, there was considerable emphasis on the fact that a formal statement of principles was almost secondary to the problem of insuring daily concern of the individual clinical psychologist for the personal welfare of his clients. As stated by a sub-committee, "To be effective, such a statement must become an integral part of the individual psychologist's personal system of values." How can a statement of ethical practices be made a part of the value systems of several thousand individuals? Some disciplinary procedures are now being used by the American Psychological Association acting through its Committee on Scientific and Professional Ethics. Other procedures will appear as licensing and certification become more widespread. Universities have demonstrated their willingness to accept the responsibility for the elimination of unethical students. Yet disciplinary measures alone may well leave the real problems largely untouched. Thus, while an early statement of ethical principles was requested as a first approach, the Conference was eager to seek other means of *insuring* ethical practices.

A second approach to the observance of ethics in clinical psychology was seen to be that of having training universities include

in the four-year program procedures that would help students to recognize and apply ethical standards. While the Conference agreed on the need for explicit treatment of ethical responsibility by training universities, it emphasized that classroom discussion is not enough. Values are acquired quite as much by daily contact with people who believe and practice certain ethical principles as by formal discussion of the difference between right and wrong. Thus, as a third approach, universities are obliged to provide supervisors and instructors who exemplify the highest ideals of the profession.

A fourth method for achieving adherence to ethical practices was presented by Dr. Nicholas Hobbs of Columbia University, chairman of the American Psychological Association Committee on Ethical Standards. This Committee is charged with the responsibility of developing a statement of ethical standards for psychologists. Its activities are supported by the Association and by a grant from the Rockefeller Foundation. The primary objective of the Committee is to devise a code of ethics for psychologists. However, the plans for achieving this objective entail activities that should result in an immediate raising of standards of ethical behavior among psychologists. The process of developing this code is considered to be almost as important as the code itself. Two aspects of the process are expected to make a significant contribution to the achievement of higher ethical standards in the profession. One aspect is the participation of many psychologists in the project, and the wide sharing of ideas concerning the kinds of things the code should cover. This joint participation should result in profession-wide attention to problems of ethics, a concern that should evoke among members of the profession a sensitivity to ethical considerations in their daily work. The second aspect consists of a direct educational program, to be carried on as the project develops. As materials are formulated, they will be distributed to universities and associations of psychologists to serve as a basis for discussion of ethical problems. This educational undertaking is considered to be of special importance to the professional development of graduate students. The techniques for identifying problems and deriving possible ethical solutions to problems constitute a "research approach" to

the development of the code. All members of the Association have been asked to contribute descriptions of incidents involving some critical ethical decision. A collection of such incidents (now numbering over a thousand) will provide a basis for an initial formulation of standards. The materials thus formulated will be submitted to a panel of some fifty representatives of various divisions in the APA, who will make a critical appraisal of the suggested standards and return the materials to the Committee for revision. Revised materials will be published to obtain a wider appraisal from members of the profession. The final statement, revised in the light of suggestions received, will be submitted to the Council of Representatives for approval. It is anticipated that the final outcome will be a succinct code of ethics for psychologists, supplemented by a considerably longer statement of ethical standards, illustrated by concrete examples of ethical issues.

Formal enforcement of a code of ethics can be brought about in a number of ways. One of the sub-groups listed the following disciplinary measures as available to professional associations when violations occur: (1) warnings to members of the association; (2) publication of full reports of investigations of violations of good practice; (3) expulsion from membership in professional associations; (4) revocation of individual certificates or licenses; and (5) revocation of professional certification for institutions employing unethical clinicians.

THE RESPONSIBILITIES OF TRAINING UNIVERSITIES

If universities are obligated to train students in ethical practices, this obligation carries with it responsibility for eliminating students who are likely to avoid or mishandle their own professional responsibilities. Unfortunately, the administrative problems that arise often constitute ethical issues in themselves: for example, is it justifiable to dismiss a first-year graduate student who is known to have committed one unethical act? In effect, the dismissal of such a student is a prediction that he will continue to be unethical. Most

such problems found in university settings lack clear-cut definition, so that only a resolute endeavor on the part of department chairmen and staffs to insure the highest standards will prove effective in establishing ethical practices among students without unjustifiably condemning individuals.

The elimination of irresponsible students should logically begin with selection procedures. However, there are few effective methods for selecting only those students known to be likely to follow ethical practices. Letters of recommendation add little useful information to a student's personnel file, since references ordinarily are obtained only from persons who the student is reasonably sure will write complimentary letters. Furthermore, very few if any undergraduate majors in psychology have been faced with the kinds of ethical responsibilities likely to arise in professional situations. The obviously unethical person rarely completes undergraduate work.

Difficult problems also arise over graduate students who are suspected of having committed unethical actions in their supervised experience or who are suspected by their instructors of being unable to abide by accepted professional practices. In some instances, suspicion or partial evidence, rather than outright proof, constitutes the only available basis for action. How much action can a psychology department take on the basis of suspicion alone? How much evidence constitutes proof? If a student is eliminated, should the action be registered with a group or officer within the American Psychological Association in order to prevent the student's transfer to another graduate school? If another university is informed of the student's having been asked to withdraw, is it bound to abide by the findings of the original university concerning the student's guilt or innocence?

In essence, these questions revolve around standard legal safeguards for the rights of individuals who may be unfairly accused. Unless continued irresponsibility is proved unquestionably, how far can a university department or a group within the American Psychological Association carry the blackballing of a student without themselves committing unethical, if not illegal, actions?

These problems were frankly recognized as real ones for which

there are no definitive answers at the present time. The magnitude of the problem can be overestimated, however, because in most instances of students found to be unethical the evidence is overwhelming, and decisive action is taken by the university concerned. In addition, few graduate students can transfer from one university to another without some communication between departments. There still remain, however, a small number of students who could conceivably effect such a transfer, especially if a number of years elapse between dismissal from one university and enrollment in another.

The Conference was unwilling to suggest that a central registry be established within the American Psychological Association at this time, but did recommend that the problem be considered by state and divisional societies in future meetings. There was no question about the desirability of permanently eliminating from further training students known to be unethical. It was felt, however, that machinery for safeguarding the rights of the individual will be necessary before a central registry can operate effectively.

Of very considerable concern to the Conference was the supervision of students in clinical practice. It was generally agreed that psychology departments should provide adequate supervision in all clinical practice. Even advanced students should not be permitted to engage in independent clinical work. It appeared that most psychology departments insist upon supervision in order to avoid mishaps due to inexperience, well-intentioned though the student may be.

RELATED PROBLEMS

A number of questions that arose are related more to general problems of the practice of clinical psychology than to the problem of unethical procedures by an individual attempting to improve his income or his status. The conflict of values is perhaps more acute in psychology and psychiatry than in other comparable professional areas. These professions are constantly engaged in attempting to alter the behavior and, therefore, the lives and personal relationships

of the clients and patients with whom they are working. Subtle ethical problems with many nuances are constantly arising. These problems harass the psychologist not only in psychotherapy, but also in research using human subjects and in situations where the clinical psychologist is employed in industry. Interprofessional relations also create ethical difficulties that may be largely unrelated to defective personal standards. These questions, as viewed by the Conference, are discussed below.

The Clinician as Scientist and as Practitioner. Several times discussion turned on the apparent conflict between the dual roles of the clinical psychologist as a research worker and as a practitioner. More concretely, can the scientist be aware of and conform to all those ethical practices that constantly surround and curtail the activities of the professional person? After discussion, the opinion seemed to be widespread that this issue is more apparent than real. In any situation the human subjects of research are constantly protected by law, by cultural tradition, and by codes of ethics. If we are convinced that the welfare of the individual is our ultimate goal, and if the scientist within our society must function within the logical framework of this conception in order to remain active in research, no real problem exists insofar as conflict between roles is concerned. The clinical psychologist as *scientist* must of necessity abide by all the ethical rules of the practitioner and must, in addition, add to these the ethical practices of the scientific tradition. (To deny the necessity of an ethical conflict when the psychologist is playing dual roles does not deny the frustration that often arises when a psychologist's service load as practitioner prevents him from carrying out the research he wishes to do. This, however, is a different aspect of the conflict arising from the dual role.)

The general ethics of the clinician as *scientist* were touched upon only infrequently at the Conference since here the traditions and practices are well known. Some borderline questions did arise. The use of unvalidated techniques or instruments often raises ethical problems, particularly when their results are included in reports going to members of other professions who may not be familiar with the limitations of the new instruments. The results of unvalidated

techniques must be reported with more than ordinary caution. Overgeneralization from a single case also continues to be a problem that often provokes ethical issues, particularly if the conclusions fit in with the personal or pet beliefs of the individual clinician. Unscientific conclusions drawn from adequate or inadequate data have many repercussions of an ethical nature when these conclusions are applied in clinical practice or reported in the literature.

It was generally agreed that research and development of new techniques are legitimate and must be encouraged but that psychologists who are engaged in such work must be certain that it results in no harm to individual patients.

The Clinical Psychologist in Industry. Where relationships with employers are concerned, the Conference was clearly in agreement that the ethical practices of the profession take precedence over loyalty to a particular employer if conflict arises. This was most clearly stated in a general session devoted to discussion of the clinical psychologist in industry. It was agreed that even though the clinical psychologist is working for an employer whose primary goal is the making of profits, he can abide by no professional code of ethics other than that of the psychologist employed by a hospital or a university. In industry *more numerous* ethical questions may arise, but their solution cannot be based upon standards different from those endorsed by the profession in general. Where a psychologist receives confidential information from both an employer and a client, he should specify in advance, and precisely, what kinds of information will be kept confidential and what will be given to the employer.

Interprofessional Problems. Although clinical psychologists do not always work as members of a mental health "team," their work almost inevitably brings them into contact with members of the related professions. While there is little possibility that problems will arise because of conflicting codes of ethics, problems do occur in the relations between members of the various professions. One sub-group suggested that the ethical codes of the related professions be published in one of the psychological journals. Another sub-group urged the planning of meetings of interprofessional groups to

correspond locally to the joint committee of the American Psychiatric Association and the American Psychological Association.

While there is no way of insuring that each client or patient receives the best possible attention, it was felt that there is an ethical demand on the clinical psychologist to be constantly aware of his own professional limitations as well as his skills. Thus it becomes his responsibility to form working relationships both with psychiatrists and other physicians and with social workers in order to meet the needs of individuals not under the care of a mental hygiene team. A resolution to this effect read as follows:

> Because of: (a) the extreme complexity and variety of problems presenting themselves for solution, (b) the equally wide variety of skills and techniques required for the most effective service to the individual, and (c) the fact that the current training of any one profession cannot possibly ensure mastery of all of these techniques—we urge clinical psychologists to adopt as a principle of practice the establishment and maintenance of active and effective liaison with members of allied professions in all service functions.

Cooperation with members of the allied professions was an ethical demand that was clearly recognized. In its wake, however, arose a number of questions that should be mentioned. How does the clinical psychologist best safeguard the rights of clients when his professional relationships are not as yet legally recognized as "privileged communications"? How does the clinical psychologist establish working relations with the best-qualified members of the related professions? In localities that may lack well qualified psychiatrists or psychiatric social workers, is it better ethics to establish relations with such psychiatrists or psychiatric social workers as are present or to make use of the help that may be obtained from other well qualified physicians or social workers of more generalized training?

Although the immediate problems of professional training and practice received the largest amount of attention, some of the more imponderable dilemmas arising from the subject matter of clinical psychology were discussed. For the psychologist as scientist, traditions and customs are apparently clear-cut and deeply imbedded in the scientific and educational traditions of science in general.

However, even as scientists and promulgators of theories about human nature, psychologists are involved in ethical issues over which they may have little or no control.

There are certain issues that now face all scientists. These have to do with the undesirable uses to which scientific knowledge may be placed. The moral concerns of the atomic physicists are hardly the immediate concerns of clinical or other psychologists insofar as their professional contributions are involved. Yet for psychology, which is engaged in an effort to understand, predict, and thereby control human behavior, ethical problems are inevitable. A theory of human personality that stems from authoritative sources and captures some segment of public interest is by its very nature provocative of ethical problems.

Clinical psychology, together with allied professions, is at present going far beyond the mere fashioning of theories. It is attempting to change human personalities. Since change may occur in a number of directions, the moral issues are more complex than those which arise when, as in medicine, the effort is primarily to restore health. The medical profession has long had an arbitrary solution for its ofttimes uncomfortable power over life and death. There the ethical issue and its solution are readily apparent. Problems of control over personality changes are not so readily apparent, nor can they always be so readily solved by reference to the Hippocratic oath that has served medicine so well.

CHAPTER 6

Background Preparation for Clinical Psychology

Curriculum planners have long been captivated by the notion that there is a "one best way" of arranging subject matter to produce the most highly qualified graduate in the shortest period of time. The Conference to a large extent disavowed faith in the "one best way" doctrine. When a single highly specific goal is to be reached, it may be possible to outline the syllabus in great detail and to arrange the courses in logical and chronological order. When, however, one is concerned with an eight-year program of college and graduate school in which the final goal is a broadly educated and scientifically oriented professional person, overspecification can present a facade of logical integration that may well be contrary to the facts.

Such fallacious "order" is particularly easy to achieve in a subject such as psychology where overlapping content is matched with overlapping or identical methods in two or more seemingly discrete areas. Even in the medical schools, with their apparently simple curricular progression from basic science to clinical application, there has been growing dissatisfaction with the "one best way" doctrine, so much so that vigorous experimentation in curricular rearrangement is under way as a sanctioned policy of American medical education.

In general, the Conference gave thoroughgoing approval to the *1947 Report of the American Psychological Association Committee on Training in Clinical Psychology.* To the casual reader, the *1947 Report* may appear to recommend a highly formalized type of training program. More careful perusal, however, reveals that its

thinking and that of the present Conference were in harmony in suggesting diversity of university training programs. Its specific provisions are to be interpreted largely as suggestions rather than as strict requirements. This more accurate interpretation (lack of which had caused many misunderstandings in the intervening two years) is grasped more readily by reading the most recent report of the same Committee that appears in the August, 1949 issue of the *American Psychologist*, pp. 331–340.

UNDERGRADUATE PREPARATION FOR CLINICAL PSYCHOLOGY

Just as requirements for college entrance largely determine the type of high school education taken by students hoping to enter college, so the requirements of graduate and professional schools are beginning to mold the undergraduate curricula of many college students. Medicine and law are two professions that have taken rather divergent stands insofar as undergraduate preparation for admission to the professional college is concerned. Law schools ordinarily suggest rather broad preparation in a large number of undergraduate departments, with specific requirements being limited to a very few basic courses. Medicine, on the other hand, has tended to prescribe a rather complete list of undergraduate requirements. The lack of social sciences in the education of most physicians has become a matter of some concern to medical educators in recent years.

Undergraduate Specialization. The two professions cited above are included here only to indicate that psychology and clinical psychology can choose the type of undergraduate preparation deemed most appropriate for their final product. The choice between a rigid set of undergraduate requirements and a flexible program that depends upon a wide selection of appropriate subject matter must be viewed in the light of the final product of professional training rather than as a simple matter of determining what courses are most likely to be useful prerequisites for graduate work in clinical psychology. To some extent the issue is one of supporting extreme specialization over the eight years of college and university

work or of encouraging, instead, a broad, general education prior to specialization.

Historical precedents in psychology are not of much assistance; there has been no generally accepted practice in this respect. Most departments of psychology have accepted as graduate students those with a relatively small number of undergraduate psychology courses as well as those with extensive preparation in psychology during the college years. It is likely that most instructors of graduate courses have been impressed at one time or another by the celerity with which some students having little or no undergraduate preparation in psychology have mastered graduate courses and obtained well-earned Ph.D.'s in psychology. The objective data on this point, however, are admittedly very meager.

On the subjective side, there has been a strong current of feeling in psychology departments that students preparing for graduate work in any field of psychology should have broad backgrounds in widely diversified subjects. Psychology occupies a peculiar position in regard to the conventional demarcation between the natural and social sciences. Particular psychologists can rightfully claim to be either social scientists or biological scientists; but no one, to the dismay of some university administrators, has ever been able to convince all members of the discipline that they are in one group or the other. The science of psychology is as concerned with the influence of experience and environment upon human beings as it is with the biological, chemical, and physical processes within the organism. Even the humanities, particularly literature, present the psychologist with a vast, unsystematized body of knowledge that he may constantly use as a check upon his speculations or research data.

Another factor that has contributed to the trend toward avoiding undergraduate specialization has been the feeling that psychologists should have a wide familiarity with people and with culture, since psychologists may be called upon to consider problems wherever human beings are concerned.

The present Conference reaffirmed the stand, taken in the *1947 Report,* for a broad, flexible undergraduate preparation. One of the sub-groups considering this topic reported as follows:

> The emphasis of our discussions was generally in the direction of retaining a broad, flexible curriculum at the undergraduate level with a minimum of specific requirements. Too early specialization tends to run counter to the breadth and versatility required of the clinical psychologist. The skills and special tools acquired at a later period must have wide and varied adaptations. For this reason, versatile orientation in modern culture is basic to the appropriate adaptation of skills and tools.

The Conference as a whole crystallized its thinking along these lines by adopting the following resolution:

> The undergraduate curriculum of the student who plans to take a doctorate in clinical psychology should approximate the undergraduate curricular contents recommended in the *1947 Report* of the Committee on Training in Clinical Psychology.

Students Lacking Undergraduate Majors in Psychology. The members of the Conference also seemed to feel that universities should not be bound by any particular array of undergraduate courses in considering exceptional students. There were explicit statements, to which no objection was made, that exceptional students with the B.A. degree, but without an undergraduate major in psychology, might well be accepted as bona fide graduate students in clinical psychology. Such students would be expected to make up subject-matter in which they are lacking, and thereby would probably lengthen their graduate programs.

A word of caution should be inserted here in order that the above recognition of individual differences should not be misinterpreted to the detriment of students considering graduate work in clinical psychology. Universities with approved training programs in clinical psychology are most likely to continue to give preference to students who meet the undergraduate requirements outlined in the *1947 Report*. In view of the very large number of candidates now applying for graduate training in clinical psychology, some universities will probably automatically eliminate from consideration students who do not meet those requirements, largely as a matter of simplifying a very expensive and time-consuming selection process. It is

likely that only very exceptional students with well-documented scholastic superiority plus a very high degree of aptitude for graduate work in psychology will be admitted without having had most of the approved undergraduate preparation.

Technique Courses at the Undergraduate Level. So far, this section has discussed what material should be included in undergraduate preparation. The Conference also gave particular attention to what should be omitted from undergraduate work in preparation for clinical psychology. With only five dissenting votes, the following resolution, pertaining to diagnostic and therapeutic technique courses, was approved:

> Courses and skills training in diagnostic or other clinical techniques should be offered only at the graduate level and only to students whose education will give reasonable assurance that the use of such skills will be made with proper regard for the best interests of clients or patients and with proper regard for problems of validity and the limited applications of the data derived from such techniques.

More specifically, the resolution urges that courses should not be offered at the undergraduate level in the Stanford-Binet, the Wechsler-Bellevue, or the projective techniques. Moreover, even at the graduate level, enrollment in such courses should be restricted to students who will have a legitimate use for them and who can be trusted to understand the limitations of the techniques themselves. Courses designed to train students in psychotherapy also fall into this category.

Many psychologists and other educators who have been teaching courses in individual intelligence tests will object to such a proscription as an illegitimate interference with their own prerogatives, if not an infringement upon academic freedom. The Conference wished to state most explicitly that there was no objection to teaching theories of measurement, theories of projective techniques, and theories of personality. Undergraduates cannot, however, be given sufficient training in psychology to permit them to use these tools properly, since each of the tools depends upon an intensive period

of supervised training before adequate interpretations can be made. Too frequently, students taking such courses receive certification in the use of the tool and qualify thereby as psychometricians or clinical psychologists. Since the profession of psychology has had a large hand in developing its clinical tools, it therefore has a responsibility to see that the tools are not put to deliberate or even unintentional unethical uses. For several decades, psychologists have stood by rather passively while "testers" with a summer-school course in the Binet or the Rorschach have naively substituted the magic of the quantitative test score or the graphic profile for a sound understanding of the limitations of clinical instruments. However, changes are already occurring. Several companies are refusing to sell test materials to unqualified persons. The Massachusetts Society of Clinical Psychologists, Inc. has already recommended to its members that technique courses be abolished at the undergraduate level. The present resolution of the Conference is still another step in the same direction. It is hoped that the Division of Clinical and Abnormal Psychology and eventually the American Psychological Association will endorse this policy.

This policy should not be interpreted as an attempt, in any sense, to limit the useful dissemination of psychological knowledge or to prohibit serious students of any discipline from learning even the techniques themselves, provided they have legitimate reasons for knowing them. In the final analysis, however, the ultimate safeguarding of the public against the unwise use of specialized techniques will probably depend upon the adoption of, and public education about, a licensing or certification program for clinical psychology.

THE GRADUATE PROGRAM IN BASIC PSYCHOLOGY

Among the many decisions clinical psychology has had to make in recent years, one of the most important has been whether to train for practice, for scientific research, or for both. The decision of this Conference, as discussed more fully in Chapter 8, was that training

should prepare students for *both* research and practice. Such a conclusion largely determines the type of program to be offered during the graduate school program. Thus it is inevitable that training universities are forced to consider the practical as well as the theoretical aspects of their course work in general psychology. Discussions at the Conference clearly indicated that there were certain very definite underlying policies upon which there was almost complete agreement. It was felt, however, that implementation of these policies in the form of specific courses and subject matter arrangement should be left to the universities themselves. Psychology, it was pointed out, is not in a position to specify exact curricula providing ideal graduate or undergraduate training for any particular goal. This is as true in clinical psychology as it is in general psychology. The encouragement of diversification may be expected to lead to more rapid progress toward better curriculum construction.

This policy does not obviate the need for a common core of knowledge and skill in basic psychology. It merely recognizes that there are different ways of organizing such a core, and that we lack, at present, sufficient evidence for preferring one organization over another.

Insofar as the contents of the basic core were concerned, there was very general agreement on the following resolution:

> There should be a common core curriculum for all students in graduate programs leading to the doctorate in clinical psychology. The goal of this core curriculum should be to educate the student to deal with psychological problems in a scientific manner and should therefore center around the areas of theory construction, conceptual tools, and scientific methodology.

This resolution clearly implies that clinical psychologists are expected to be thoroughly familiar with such basic concepts and methodology of the science of psychology as are generally recognized. Thus the graduate student in the clinical area is also a graduate student in general psychology. This further implies that clinical psychologists conceive of their profession as an applied

branch of the general field of psychology rather than as a separate profession. Many theoretical objections can be raised to such a decision, but its practical consequence—that clinical psychology wishes to maintain its identification with the broader field of general psychology—seems to be generally accepted. Implementation of this goal seems to require that graduate students in the clinical area should have close and prolonged contact with well-qualified graduate students in other areas of psychology, since much education takes place at the personal as well as at the classroom level.

The sub-groups that considered the topic of "basic psychology for clinical students" prepared the following report on areas of general agreement:

1. The goal of the core curriculum is to educate the student to deal in a scientific manner with problems and problem areas in psychology.
2. The minimum basic core of training for clinical students should not differ essentially from that of other graduate students in psychology.
3. This minimum basic core of training should center around three objectives: theory, conceptual tools, and methodology.
4. These objectives should be regarded as guiding principles throughout the *entire* training program, though various courses may differ in title from one university to another.
5. A permanent committee at the departmental level and another at the Association level should be established for the purpose of continued re-examination of and recommendation with regard to the basic problem areas and the course structure of graduate training in psychology.

Departmental Responsibility for Basic Courses. The last recommendation, that a departmental committee consider the curriculum in basic psychology, met with little resistance at the Conference, although it was pointed out that such a departmental committee might well violate the tradition in many universities that instructors in graduate courses are quite capable of determining the content and procedure for teaching their own courses. The basic issue seems to hinge upon the stake that other members of a graduate department have in the so-called basic or required courses.

No one at the Conference implied that the basic courses should be approved in all details by the department or the departmental committee. Such routinized and mechanized treatment at the graduate level is quite likely to rob the instructor of initiative and hinder him in creative methods of teaching. There was a feeling, however, that the contents of the basic courses should be known to other members of the department and that arrangements should be worked out so that important segments of information are not neglected. This is, of course, what usually happens within psychology departments, although failure to achieve such cooperation has sometimes resulted in the proliferation of overlapping courses, and a consequent additional encumbering of the graduate student in clinical psychology, who already has an overcrowded schedule.

A representative from one university that has agreed to departmental responsibility for basic courses reported that this policy is always stressed as accepted procedure when applicants for teaching positions are being interviewed.

Overlapping Courses. Another university representative described a recent survey made by graduate students concerning the question of course duplication. The results showed so much overlap that the staff has since been engaged in strenuous attempts to eliminate a great deal of overlapping factual material. However, the staff is making no effort to dispense with overlapping theory, since review of theories from different standpoints seemed desirable to the students.

The following resolution was generally approved by the Conference, although one participant strongly disagreed and ten had reservations:

> The objectives of integration of course content with learning experiences and of conserving time in the graduate education of clinical psychologists may be furthered by having the department of psychology take active responsibility for the planning and approving of content in core sequences and in required courses.

The problem of overlapping courses is generally recognized in psychology and constitutes a rather serious problem in curriculum construction. Many present-day psychology courses are organized

around areas of application, such as "Social Psychology" or "Psychology of Adolescence," with the result that general principles, common to both courses, receive double coverage. To some extent our present situation justifies this procedure, since psychology very largely lacks unifying principles that have valid application in all content areas.

This situation has produced a large number of courses that have legitimate existence as separate courses in their own right but that tend to make the graduate curriculum quite unwieldy from the standpoint of attempting to train students in applied areas in a reasonable length of time. Participants at the Conference frankly recognized that clinical students cannot be expected to master all areas of psychology in addition to the clinical area. One sub-group stated the objectives of the Conference, in this regard, as follows:

> We recognize that the subject matter of psychology is so diverse that it is impossible to include adequate treatment of all its areas of knowledge in a graduate program. This fact indicates that basic core instruction calls for an integration of content, on a representative and non-overlapping basis, into the few courses considered valuable to *all* graduate students in psychology. Organization of individual courses around integrated constructs rather than around content areas appears desirable.

This is certainly a laudable objective and will probably be more widely achieved as psychologists become more familiar with the problems of training graduate students for applied areas.

Core Courses in General Psychology. So far as specific subject matter of courses in the basic core is concerned, the Conference was quite willing to endorse the *1947 Report of the Committee on Training in Clinical Psychology,* which was viewed as a guide rather than as a listing of required courses and course titles.

One interesting proposal in regard to the underlying rationale of the core curriculum was worked out by a sub-group and presented to the Conference as a whole:

> Psychology is concerned with behavior and experience, both normal and abnormal. In order to understand these, it is necessary to know the variety of factors which determine them. Such factors

can be found in heredity; in anatomic, physiological, and organismic data; in the interaction between nature and nurture; in maturation; and in the individual's experience of both his relation to the group and the influences of the group upon his behavior. The core curriculum should make provision for the study of these factors and for instruction in the methods for examining, determining, measuring, and understanding them.

Two specific subjects, statistics and foreign languages, were initially brought up under the present topic of core curriculum and resulted in prolonged discussions that extended into other topics. The Conference's conclusions in regard to statistics courses are presented in Chapter 8. The subject of foreign languages is treated in the next section of this chapter.

FOREIGN LANGUAGE REQUIREMENTS FOR THE PH.D.

Marked and continuous disagreement was obvious throughout the Conference whenever the subject of requiring foreign language proficiency was mentioned. There was no doubt that somewhat more than half of the participants were in favor of abolishing the foreign language requirement from the graduate program for clinical psychology students. Many of those who favored dropping the requirement felt, however, that demonstrated proficiency in one or two foreign languages should be required for *admission* to graduate work, so that the language will be available to the student as a tool throughout graduate study. Several representatives felt this suggestion might be feasible in view of the large number of applicants. Only a few participants were in favor of retaining the present requirement of many institutions that reading knowledge of two languages be presented by the candidate before the Ph.D. is awarded. The following tabulation resulted from a questionnaire distributed to all university representatives concerning present practices:

20 Universities require two languages but give the student a choice of the languages on which he will be examined.

10 Universities require French and German with no choice permitted.
7 Universities require one language plus competence in an additional skill such as advanced statistics.
4 Universities require only one language.

There are still other variations practiced by some universities, such as permitting the student to present either a reading knowledge of two foreign languages or a comprehensive reading and oral knowledge of one. Some universities require knowledge of one foreign language for the M.A. degree.

The one area of agreement was centered about the proposition that there should be no difference in the language requirements for clinical and nonclinical students in psychology. It is evident that opposition to foreign language requirements extends well beyond the field of clinical psychology, but there is little agreement on what should be done. Three of the larger universities, Minnesota, Harvard, and Ohio State, have recently polled all their living Ph.D.'s in psychology on this question. The results of one of the studies* revealed that at the most not more than ten per cent of living Ph.D.'s from one university actually use their supposed knowledge of foreign languages. The other two studies are in essential agreement.

Various participants at the Conference voiced a number of strong opinions in support of the retention of foreign languages in the graduate curriculum. These defenses, summarized below, were not necessarily advanced by persons who wished to retain the present requirements. They do represent, however, some of the perplexing questions that face any group considering abolishment or modification of the requirement.

Several references were made to the fact that science is an international affair and that abolishment of requirements for foreign language competence will cut us off from knowledge obtained outside English-speaking countries. Second, the Ph.D. degree represents scholarly achievement, which includes acquaintance with the science

* Bird, Charles, *et al.*, "The Foreign Language Requirement for the Ph.D.," *American Psychologist,* April 1947, *2,* 136–138.

and scholarship of other nations as well as our own. Since we have agreed to retain the Ph.D. degree rather than ask for a separate professional degree, we will be expected to abide by the graduate school rules generally provided for all Ph.D.'s. Third, the issue should be settled on local levels in the interest of retaining university autonomy.

These arguments in defense of retaining the present requirement were also supported from several sectors by the well-known fact that abolishing such a requirement has met with opposition and considerable failure wherever a psychology department has made such a proposal to its own graduate school.

The chief arguments for modifying or abolishing the requirement seem to be the following. First, the three studies mentioned above clearly indicate that only a few psychologists, usually those in research positions, actually know and use a foreign language. Second, students and many faculty members feel that the foreign language requirement unnecessarily diverts students' energies from tasks that are much more important to their professional future. Third, the practice of substituting a skill such as advanced statistics for at least one language has met with general approval in universities where it has been instituted, and the practice seems to appeal to many psychologists from other universities. Fourth, the present system of forcing students to learn foreign languages results in the minimum preparation necessary to pass the examination; and passing an examination seldom signifies actual competence in that language.

The Conference arrived at no agreement in regard to foreign language requirements. Strong opposition sprang up whenever changes from the *status quo* were suggested. Strong opposition to the *status quo* also exists. There is little doubt that this question will be with us for some years to come.

CHAPTER 7

The Core Curriculum in Clinical Psychology

The Conference found very general agreement in the following resolution:

> The core curriculum in clinical psychology should approximate that recommended in the *1947 Report of the Committee on Training.* It should have the triple goal of teaching content, developing skills, and inculcating attitudes. It should be so organized that both diagnostic and therapeutic techniques are taught in integrated relationship to theories of personality and behavior.

Areas of the Core Curriculum in Clinical Psychology. In order to provide a brief survey of the areas thought to be important in the clinical training program itself, the following twelve fields are reported as those which one sub-group agreed unanimously should be included in a core curriculum. One should keep four points in mind while reading this list. First, this list does not represent twelve recommended *courses* but is a listing of *areas* that might be organized into courses in various ways. Second, much of the material mentioned has already been presented in the basic psychology required of all doctoral candidates. The list, therefore, is not quite as overwhelming as it might appear at first glance. Third, the Conference as a whole neither approved of nor recommended the list as a core curriculum to be followed in all details by training universities. The list does nonetheless represent the collective thinking of one-fourth of the participants. When it was presented to the general session, no striking disagreements were voiced. Fourth, the list is presented without implying any ranking of the fields in terms of relative importance. No weights, representing relative amount of

time considered appropriate for each item, were worked out. Thus the list can be considered as defining, rather roughly, the basic areas with which clinical training programs are concerned and about which the even more basic underlying philosophy of clinical psychology training takes shape.

1. *Human Physiology:* The sub-group included this material with explicit recognition of the prerequisite training ordinarily required for course work in physiology, endocrinology, neurophysiology, and neuro-anatomy.*

2. *Personality Theory:* This area should include both cross-sectional and genetic theories.

3. *Developmental Psychology:* As used here, the term refers to psychological development and change throughout the life span. Training in this area should deal with the biological, sociological, and cultural determinants of psychological development.

4. *Social Relations:* The term refers explicitly to material in social psychology, sociology, economics, and anthropology.

5. *Psychopathology:* It is not intended that work in this area should be concerned primarily with the gross abnormalities found in mental illness. (See No. 7 below.) It should cover the psychology of deviant personality.

6. *Personality Appraisal:* This area includes all the methods available to the clinical or nonclinical psychologist for evaluating the individual and groups of individuals. In addition to testing methods, it also refers to interviewing, observation techniques, and the like.

7. *Clinical Medicine and Clinical Psychiatry:* It is here that training concerning the nature of kinds of mental illness is to be included, together with such basic information in clinical medicine as is appropriate and necessary for the nonmedical clinician.

8. *Psychotherapy and Remedial Procedures:* The latter half of this designation is added, not as an attempt to differentiate remedial procedures from psychotherapy, but to indicate that training in such areas as relearning and remedial reading should be included.

* Several participants questioned the practicability of including these subjects in an already crowded curriculum.

9. *Clinical Research Methodology:* There are enough research problems peculiar to the clinical situation to require special training in this area. The usual training in research methodology does not necessarily cover this area.

10. *Professional and Interprofessional Relationships:* This area involves explicit attention to the nature and functions of allied professional groups, relationships with one's own professional colleagues, and all other phases of professional ethics. (See Chapters 5 and 13 for more complete discussions of ethics and of interprofessional relations.)

11. *Community Resources and Organization:* The clinical psychologist must know a great deal about the resources, agencies, and institutions of the community. He must be familiar with their operations and the protocol involved in working with them. With respect to methods of training in this area, much can be learned from the experience accumulated by psychiatric social workers.

12. *Practicum and Internship Experiences:* (Chapter 10 discusses this area.)

Organizing the Clinical Core. As might be expected, Conference participants found little agreement when attempts were made to organize this material into specific sequences. As reported by one sub-group, some participants felt that the best results could be obtained by starting with pure theory, others advocated initiating training with testing techniques, and still others thought that psychotherapy with simple problems gives the student the best overall introduction. In this connection, it appeared that the *1947 Report of the Committee on Training* went somewhat further in designating course sequences and year levels than the Conference was willing to go.

Despite the fact that agreement on specific procedures for teaching core materials was not found, the underlying principles that determine how the material is taught in terms of expected outcomes and underlying philosophy found a surprising degree of general agreement. The following principles, like the twelve areas listed above, cannot be regarded in the same light as the Conference

resolutions, but they also seemed to meet with no serious objections and can be accepted as guides for developing and assessing the core curriculum in clinical psychology.

One sub-group suggested the following three principles as useful guides in determining the relative emphasis to be placed on each aspect of a clinical method at a given point in training:

1. The sequence of emphasis should be from:
   (a) the theoretical aspects of a given procedure, to
   (b) the technique of its administration, to
   (c) its interpretation, to
   (d) its full clinical use.
2. Supervised experience in the observation of patients should precede use of formalized procedures.
3. Clinical responsibility should be introduced early in training and progressively increased in degree. The extent of responsibility placed on a student at any one moment is a function of the degree of competence developed by the student and the degree of skill required by the task.

Definite efforts should be made to avoid technique-centered training. In the core curriculum, students should become acquainted with many diverse theories rather than with any single viewpoint. While it is more important for a student to know the theory underlying the methods than to have competence in any specific technique, he should be expected to develop, before completion of the program, a considerable degree of skill in a minimum number of diagnostic and therapeutic methods. Students completing the Ph.D. will, of course, be expected to have competence in necessary job skills. The methods chosen may well vary from time to time as the scene in clinical psychology changes or as the student prepares for specialization in particular areas of the field. Emphasis on theory, general principles, and critical analysis provides a basic framework for quickly learning and evaluating new techniques.

A more specific description of the goals felt most suitable for training students in clinical methods was prepared by a special committee considering technique courses:

The goal of training in clinical methods is twofold: (a) acquiring enough knowledge of the whole range of clinical methods to be critically selective, and (b) achieving demonstrable proficiency in one or more methods in each of the following categories:

1. Observation, including the role of the participant observer.
2. Interviewing, ranging from a highly structured, standardized approach to unstructured therapeutic interviewing.
3. Administration and interpretation of objective diagnostic tests of general and special ability, achievement, interest, special functions, and deficit.
4. Projective procedures, individual and group, in verbal and action media.
5. Case integration methods appropriate to (a) treatment plans, and (b) research.
6. Therapeutic and remedial procedures.
7. Research techniques appropriate to the management of data secured from clinical procedures.

Another guiding principle brought out was that core training in clinical psychology should have administrative unification and an organizing philosophy rather than be composed of a series of discrete courses. On this score, the Conference found ready agreement and voted almost unanimous approval of the following resolution:

> Integrated courses which reflect the basic principles of psychodynamics, supplemented by adequate and carefully supervised experience in practical clinical situations, are preferable to a series of single, discrete, technical courses.

This resolution clearly proposes that academic course work should be closely integrated with practical work at all laboratory, clerkship, and internship levels. This may be accomplished by such methods as the development of a departmental clinic, the appointment of field supervisors to positions on the department staff, the preparation of syllabi whose purpose is to integrate field experience with course experience, and the keeping of careful records of the experience of each student in specific diagnostic and therapeutic methods.

The Place of Technique Training. On one point that has provoked considerable concern among psychologists over the past few years the Conference found what appeared to be eminently satisfactory agreement. Many clinical psychologists seem to have become engrossed in the development and application of specific tests. In retrospect, this concentration on techniques was to be expected, since the field as a whole has only recently discovered a wide variety of new techniques and methods, and these require a good deal of exploitation in order to determine their clinical value. The technique-centered movement has, however, aroused considerable anxiety because of its apparent influence in making the clinical psychologist a segmental specialist. The Conference accepted without dissent the proposition that in reality the training program should emphasize a totalistic approach to the individual, including the society in which he lives. The training should not develop a "test-oriented" philosophy, but should inculcate the view that tests constitute merely one of the means for trying to understand the problems of the individual client or patient.

As part and parcel of the well-supported effort to avoid a technique-centered curriculum, the Conference agreed that two important attitudes should be fostered in the student from the beginning: he should be indoctrinated in the critical appraisal of the techniques he employs, and he should be taught a sense of deep responsibility for his clients and patients. In other words, it is the individual client or patient who is most important; the techniques, if properly understood, provide methods for helping the clinician to understand him. Proper understanding cannot be obtained by learning only what is currently accepted about a given technique; proper understanding must include methods of thinking about, investigating, and evaluating techniques as more knowledge becomes available.

One practical consideration that has led to much discussion of curriculum organization relates to the problem of recent tendencies to add new courses as additional clinical methods are developed. Carried to an absurd extreme, this tendency, some psychologists have feared, might eventually result in a separate course for each

test in the clinical psychologist's repertoire. One sub-group reported, however:

> Proliferation of method courses need not be a problem unless we make it so. New techniques should not be added to the curriculum merely for the sake of acquiring more techniques; such additions should be justified on the basis of a definitely felt need for better methods of exploring psychodynamics.

It was also emphasized that single courses for the teaching of specific techniques should not be encouraged, although a specific technique might be emphasized in a given course. Single courses presenting various techniques and varying theoretical viewpoints were recommended. These suggestions for avoiding the indefinite multiplication of courses seem to point up the principle stated earlier in this chapter: that the clinical core in the training program should be oriented around theory and general principles so that acquisition of new techniques comes as a matter of application and intelligently informed discrimination. This principle also imposes on the instructor the responsibility of viewing his task as one that requires the highlighting of basic principles rather than overly meticulous attention to the innumerable details in which each technique is embedded.

Other sections of this report have emphasized certain principles of curriculum organization that need only be mentioned here. For one thing, emphasis should be placed on prevention as well as on detection and treatment. Also, in line with many previous suggestions, the Conference accepted the principle that well qualified members of other professions should be included wherever possible in the academic as well as in the field-training programs in order to bring about greater integration among the members of the mental health team. Students in clinical psychology should also have some opportunity for training in situations where they have close contacts with students in the other disciplines. It is also the responsibility of the university to provide sufficient instruction and practice in clinical methods to free the clinical agency from the necessity for basic didactic teaching. There also seemed to be widespread acceptance

of the statement that the most important single factor in teaching clinical methods is adequate individual supervision.

GENERAL REVIEW OF THE *1947 Report of the Committee on Training in Clinical Psychology*

Toward the close of the Conference and after most of the specific topics directly related to the training program had been discussed, one afternoon was set aside for examination of the recommendations of the *1947 Report of the Committee on Training in Clinical Psychology.* The general conclusions of that discussion are included here both as a summary of material presented in this and the previous chapter and as an introduction to the chapters that follow immediately. (The *1947 Report of the Committee on Training* is to be found in the Appendix.)

Three alternatives were open to the Conference in reviewing the *1947 Report:* it could (1) endorse the curriculum provisions, (2) replace these provisions with a new and specific set, or (3) specify modifications. Each of the sub-groups apparently arrived at the same conclusion that "We should endorse the report and recommend its review together with a number of comments." The following topic headings correspond to those found in the *1947 Report.*

Undergraduate Core Curriculum. Departments must require specific undergraduate programs or face the possibility of having to extend the graduate program beyond the present four-year span. (It should be noted that one special committee suggested that the graduate program should be defined in terms of four *calendar* years rather than four academic years, since most Ph.D.'s now completing their training are actually spending the equivalent of four or more calendar years.) Such specification of undergraduate training content is *not* inconsistent with a broad arts and science education. Students should have a "minimal major" in psychology at the undergraduate level. Training in related fields rather than a premature concentration in Psychology provides a suitable undergraduate background. If information on departmental graduate entrance requirements were disseminated to students and under-

graduate advisors, the present confusion would be reduced.

Technique courses should not be moved down to the undergraduate level as an expedient solution to the problem of time pressure.

General Psychology. The general psychology section of the curriculum should be described in terms of fields or content areas rather than in terms of courses. The word "course" suggests a detail and explicitness beyond that intended by the Committee on Training. *This comment applies throughout the present report.* Competence in the various areas of general psychology can be insured either by course requirements or by examination. Each university will have to work out its own particular course and scheduling structure in terms of the local situation.

Psychodynamics. It was agreed that the areas suggested under this heading should all be included in training, but it was also recognized that the classification system employed in this connection by the Committee on Training was but one of many possible systems. Most departments now offer courses which, under various headings, cover a substantial portion of the suggested topics (e.g. "personality," "abnormal psychology," "mental hygiene"). Experimental dynamic psychology might be a major exception. Here, however, the discussion brought out an important function of the Committee, that of stimulating improvements and research in the field. If the Committee is to be anything more than a device for dignifying current training practices, it must keep at least a few steps ahead and stimulate universities to new experimentation where local conditions and staff permit. Several institutions have reported favorably on their experiences with newly organized courses in experimental dynamic psychology.

Diagnostic Methods. The following passage is quoted from one sub-group's report:

> The currently increasing emphasis on and proliferation of discrete technique courses in place of an integrated stress on clinical methods both harms and encumbers training. Such proliferation also tempts us into extending the length of graduate training programs beyond their present span. Anxieties concerning the adequacy of the staff's

own preparation as clinicians and an overpaternalistic attitude toward students provide additional pressures in this direction. Just as standard movie scenarios imply that marriage ends the story, we seem to give the impression that the Ph.D. will terminate the student's intellectual growth. We act as though the student could not learn without our detailed supervision. And this in the face of our confused doubts concerning the validity of what we are doing! Let's have a little more faith in the potentialities of our students. They are, after all, a carefully selected group.

The development of explicit post-doctoral training programs will probably be helpful to prospective specialists and anxiety-reducing for instructors. Nonetheless, realism demands the planning of basic programs which can be contained within four years.

Departments should be encouraged to review and revise their curricula in order to reduce overlap and to increase efficiency through greater integration (e.g. cooperative courses, pro-seminars). A time limit on graduate training has value in that it forces such house-cleaning.

Related Disciplines. Busy students may not be able to meet the extensive prerequisites for standard courses such as anatomy, chemistry, and the like. We urge the development of courses or learning experiences in such areas, specially designed for psychologists, as a means of attacking this problem.

Research Methods. The importance of pre-dissertation research for preparation and training was reaffirmed. Universities must give some thought and effort to dissertation formulation during the second graduate year if the student is to make dissertation research an effective part of his internship. This demands realistic collaboration with the internship facility at the planning stage.

Year-Level Problems. The Committee's suggestions for first- and second-year-level functions seem to be well on the way to general adoption as a working plan. The situation with regard to third- and fourth-year-level functions will improve as the program for the first two years is clarified, because the time spent in field facilities during that period will be reduced. There is a necessity for flexibility in programs for the third and fourth year because of differences among students and among universities. The importance of

reasoned deviations from standard practice rather than deviations based on expediency or rationalization after the fact was stressed. The universities must think through their own programs in the light of their needs and assets and act accordingly. Otherwise, the curriculum provisions of the *1947 Report,* or any other report of that kind, cannot apply to the unique problems facing each training university.

CHAPTER 8

Training for Research

Perhaps the most challenging issue debated at the Conference concerned the role of research in the training of the clinical psychologist. Neither tradition nor the definition of "clinical psychology" provides much guidance. Clinical psychologists have functioned in many different fields, from research planning to full-time psychotherapeutic treatment. Major emphasis in the past (as well as in the present) has varied from producing a statistically sophisticated theorist to preparing a service-oriented practitioner. Despite the broad outlines of the *1947 Report of the APA Committee on Training in Clinical Psychology,* training institutions have never had, until the present Conference, an opportunity to reach an accord on the goals of training in clinical psychology.

The decision of the Conference to recommend the training of the clinical psychologist for research and practice, with equal emphasis on both, is likely to chart major policies in training institutions for some time to come. This was not a compromise to resolve a dilemma, although it was apparent from the beginning of the Conference that there existed two divergent opinions. A few participants were strongly in favor of concentrating exclusively on training for service. For them, insistence upon research training seemed to dilute and weaken the necessary training for competence in diagnosis and treatment. Some other participants were as strongly opposed to diluting a good research training with time spent on applied diagnostics and therapy. To this second group, the effectiveness of clinical psychologists as service workers is still a matter of conjecture. Perhaps we have been able to diagnose and treat and receive recognition for these accomplishments: but on what basis

and with what results? *Faute de mieux?* For this latter group, more science and more training in research were seen as the best answers to our present inadequacies. Both groups pointed to possible difficulties in training the same person in two different roles: as researcher and as clinician.

In the face of such an apparent split, reconciliation was surprisingly rapid and almost unanimous. This was even more surprising in view of the risks involved in deciding to train students in both areas. Training of properly selected persons in one *or* the other area is known to be quite feasible. Combining the two is an almost unique experiment in professional training.

Reasons for Preparing Students in Both Service and Research. The resolution of the opposing points of view seemed to depend largely upon five points:

1. Graduate students, it was agreed, should receive training in both research and practice in order to develop interest and background in both areas. Following completion of training, some persons might well continue to be active in both areas; others might concentrate on one.

2. The manifest lack of dependable knowledge in clinical psychology and personality demands that research be considered a vital part of the field of clinical psychology. Participants at the Conference displayed considerable humility with respect to confidence in present techniques.

3. There is little evidence to show that interest and competence in both areas are unlikely to occur in the same person. There is considerable evidence that certain individuals are capable of both. With the number of applicants far in excess of our training facilities, selection can be aimed at students capable of being trained in the double role.

4. Effectively performed service functions provide an avenue for bringing psychologists into intimate contact with the significant problems of research.

5. Effectively performed service functions have provided in the past, and probably will provide in the future, a means whereby research in clinical psychology and psychiatry will obtain much-

needed financial support for the initiation and continuation of research projects. Competence in service does not insure competence in research, but recognized competence in service is likely to provide support for research as a means of obtaining better answers to current problems.

That the Conference reached rather clear-cut agreement on the need for training in a double role should not be interpreted as a complete resolution of all issues involved. Leading members of the profession are strongly identified with one or other point of view. Certain universities strongly emphasize one area to the relative neglect of the other. Not all students are equally capable in both areas, nor can all interests be channeled along both approaches.

Perhaps the most significant and far-reaching aspects of the decision to train students in both realms are the implications for the formal definition of clinical psychology as a professional field of endeavor. The door is left open for persons of varying interests and aptitudes. Freedom of choice within a larger occupational area is possible. Specialization by a large group of individuals has certain well known tendencies to produce narrowness of thinking and rigidity of action. When, however, persons within the same general field specialize in different aspects, as inevitably happens, cross-fertilization and breadth of approach are likely to characterize such a profession. Whether the four-year doctoral training program, which emphasizes both research and service, will achieve the desired result is a question to be settled by the future. The Conference was clearly unwilling to see clinical psychology defined exclusively in terms of either research or service alone.

Motivation for Research. If training programs in clinical psychology are to produce the desired research viewpoint and competence, special educational efforts will be necessary. Many if not a majority of present-day graduate students in clinical psychology are attracted by the opportunities for professional application. It was generally reported at the Conference that students in clinical psychology experience much more difficulty with doctoral and other research than those in other degree programs. There is considerable dread of becoming committed to a lengthy thesis problem. Students

lack confidence in their abilities to do research, and their clinical interests often make research appear as a noncontributory, time-serving requirement. The educational task faced by psychology departments seems to be one of stimulating interest in research without stifling or frustrating the student's spontaneous interest in problems of personality diagnosis and therapy. The Conference felt that the task is one that requires a frank facing of the motivational problems rather than a forcing of students into compliance.

A general report from the four groups that discussed research listed the following methods whereby research can be made more meaningful to the graduate student:

1. An active research program within the department, especially in personality and clinical problems.
2. Association with able and stimulating research workers.
3. Research activity by the student early in his graduate program, and continuation of at least minor research problems throughout his training period.
4. Joint research seminars in which both clinical and nonclinical teachers and students participate. Such seminars could, at least in part, be devoted to thesis and dissertation problems at their conception and during various later stages of their development.
5. The introduction of problems in clinical and abnormal psychology into general courses in experimental and statistical methods.
6. Group research upon clinical problems.

Two topics from the above list need special consideration and are therefore discussed below: No. 3, above, refers in part to the Master's degree; No. 6, group research, represents an unresolved issue that will probably receive much discussion for years to come.

Research and the Master's Degree. Although the problem of training at levels below the doctorate is more fully discussed in Chapter 4, it should be noted here that the Master's degree in psychology has been a device for initiating graduate students into at least semi-independent research activity. Following the second World War, many institutions dispensed with this degree in the training of clinical psychologists for the Ph.D. degree. It was recognized that those persons with the doctoral degree had little

need for an M.A. after their name. When supervisory staffs were overworked, elimination of the M.A. thesis reduced some of the burden. It was hoped, moreover, that abandonment of the M.A. degree would speed up the production of clinical psychologists.

Most of the above-mentioned pressures are still in operation. Yet, as reported by various participants at the Conference, the M.A. degree is still awarded to doctoral candidates in a number of institutions, largely because of the training values of thesis research. In some centers, that degree has also been used as a means of providing the student whose training is cut short, voluntarily or otherwise, with some tangible evidence of one or two years spent in graduate study. Furthermore, the student's success in an early research problem is often thought to be predictive of later proficiency in research. Thus the M.A. degree is often used as a basis of selection for advanced graduate work.

While no effort was made at the Conference to encourage the reinstatement of the M.A. degree, there was very general agreement that a research project comparable to the usual M.A. thesis was a desirable introduction to the research required for the Ph.D. dissertation. The awarding of the M.A. for such research was felt to be a matter for decision by the training institution. The research experience itself was generally agreed to be extremely desirable, not only as preparation for later research, but also as a means of removing some of the fears and misconceptions that students are likely to develop when they have had no personal experience with such mysteries. A resolution on this point reads as follows:

> Because research competence is acquired largely by doing research, orientation to research problems should be continuous throughout the graduate program; and, possibly, one or two minor research problems should be done by the student in preparation for the dissertation as the culminating evidence of research competence.

The purpose of discussing the M.A. degree in this section is to emphasize that the Conference regarded the research aspect of such a degree as important. The Ph.D. dissertation should be neither the first nor the last research! The actual awarding of the M.A. degree

and the vocational implications of the degree itself, so far as clinical psychology is concerned, are matters that involve many more problems than provision for early development of interest in research investigations.

Group Research. There was little or no inclination to abandon the Ph.D. dissertation in the training of clinical psychologists. Efforts were devoted, however, to discovering methods of improving motivation and encouraging more effective research among graduate students. It is well recognized that most problems in clinical psychology and normal and abnormal personality are extremely time-consuming if collection of data from clinical subjects is involved. Cooperative activity reduces the time consumed in this phase, and also, as a means of increasing the significance of research, tends to arouse more interest by social facilitation.

On the negative side, the difficulty in assessing the actual contribution of an individual student in a group project was recognized and accepted as a fact. On the positive side, group research seems to be generally accepted by the profession at large as a means of improving the quality of work accomplished and of bringing several points of view to bear on complex questions. Therefore, it was asked, should we not be training students to meet the actual demands of post-doctoral research rather than clinging to a tradition of a single "independent" contribution as evidence of proficiency for the Ph.D.?

No formal decision was reached on this topic despite the considerable amount of time devoted to it. In general, there was a willingness to consider cooperative dissertations that showed clear evidence of each student's independence in formulating, designing, executing, and interpreting his share of the project. The following resolution was generally approved, with a small minority indicating some disagreement:

> Group research is a desirable and practical medium for the execution of the doctoral dissertation provided there is a part of the research for which each student has assumed *particular* responsibility, which he can in all accuracy call his own, and which he is prepared to defend as his independent work.

Research Skills in Clinical Psychology. What special skills in research are most likely to produce results that will overcome tendencies toward academic, sterile, and unimaginative investigations? This question cannot, of course, be answered by listing a set of rules for insuring productive and significant research. Sophistication in research methodology does not necessarily insure that significant ideas will be developed and expanded. Yet the Conference did seek for policies that might be of particular help in the training of clinical students. None of the research skills mentioned in the following rules are particularly new. A different group of psychologists might well extend the list:

1. *Students should be trained to make relevant analyses of clinical phenomena in order that fruitful concepts and hypotheses may be developed.* New ideas, or insightful rearrangement of old hypotheses, are badly needed in the psychology of normal and abnormal personality. In an empirical science, observation and analysis still remain the most important tools for understanding *what* problems are in need of further investigation and *what answers* are likely to be permitted by the facts observed. Clinical phenomena are probably no more abstract than those in other fields of psychology, but the methods and concepts applicable to specialized research areas may not be immediately applicable to the clinical field. Training in *relevant* analysis presupposes an intimate acquaintance with clinical phenomena and the ability to separate preconceptions and inferences from observations.

Intensive studies of individual cases might well reveal the significant variables required for an adequate scientific account of personality dynamics and change. The value of the individual case study as a legitimate research for an advanced degree has been debated for a number of years. One cannot, however, question the case study as a means for making intimate observations, for getting "close to the data," for securing "clinical phenomena" that demand explanations, and for making dramatically evident our present lack of understanding. *Relevant analysis* may be seen by the student as an intrinsically interesting kind of clinical activity, and may stimulate an intellectual demand for order and explanation.

2. *Students should be trained in the careful definition of concepts as a check upon the "intuitive" judgments often required in such practical situations as staff meetings and clinical reports.* Psychologists have long recognized the pitfalls of hazy definition and semantic confusion. Operationism as a tool for examining some of the esoteric language of psychology has received increasing attention.

Too often, however, clinical psychologists have been trained in rigorous thinking about nonclinical subject matter, and clinical problems have been dismissed as lacking in "scientific" respectability. As a result, many clinicians have been unable to bridge the gap between their formal training in scientific thinking on the one hand and the demands of practice on the other. As time passes and their skills become more satisfying to themselves and to others, the task of thinking systematically and impartially becomes more difficult.

Such compartmentalization of thinking could to some degree be avoided by a training program which frankly recognizes that, much of the time, thinking in a practical, clinical setting requires suspension of highly critical, analytical concern over constructs, especially where immediate problems of human welfare are involved. The clinical psychologist ordinarily functions in a social setting in which abstract ideas cannot be debated at all times, but where practical decisions must be reached by a number of persons with differing backgrounds and skills. Realization of the need for adaptability should, in the long run, free the clinical psychologist from feelings of guilt over the "unscientific" demands of clinical reality, if at the same time he has had opportunity to learn how to analyze personality concepts in terms of their systematic implications. There cannot be overindoctrination in the scientific attitude. There can be an illusory oversimplification of the problems faced by the clinical psychologist who is also a scientist.

3. *Students need training in the explicit formulation of research problems and in the design of appropriate investigations in the field of personality and clinical problems.* Research training for "rat" psychology is probably most efficiently accomplished by lengthy exposure to problems in which rats are the objects of observation

and discussion. No one can deny the likelihood that some transfer of training to other fields takes place. Nonetheless, the problems of human beings may demand approaches other than those used in studying the lower animals. If rigorous thinking can produce good research in animal psychology, equally rigorous thinking should be possible where humans are concerned. Proper methodology and crucial issues in the field of personality may be more difficult to establish and define; the problems faced by one field of science are rarely if ever solved by a simple carry-over of techniques and concepts from another field.

4. *Students need competence in the statistical analysis of data.* "How much statistics?" turned out to be a question akin to "How much science?" It was recognized that simple formulations of problems were often more important to clinical psychology than involved statistical analyses that demonstrate competence in statistics but show little insight into psychology. One can accept the truism that psychology is not mathematics and still recognize that mathematics can be useful to psychologists. Statistical terms and concepts form a good part of the language of present-day psychological research. From the standpoint of meeting future demands, today's students in clinical psychology will need more than one course in this subject in order to have sufficient proficiency to master new statistical techniques on their own.

In addition to the fact that statistics is useful as a tool for research analysis, statistical proficiency is often involved in the services expected of clinical psychologists in a clinical setting. In the mental hygiene team, the psychologist is often the only person with training in both research design and statistics. Administrative research, which seeks to find answers to problems of practical policy and may often determine whether or not theoretical research should be undertaken, also demands such skills.

It is obvious that no agreement can be reached on the length of time or the number of courses to be required in statistics. At various times, suggestions were made that the requirement should include "more than one course" or "a second graduate year." The real issue relates to competence in a subject-matter area and not the

number of credit hours on the transcript. Statistics is one of the few relatively well organized areas in psychology in which competence of any degree can be measured rather objectively. The *optimal* degree of competence in statistics for clinical psychologists is probably a meaningless question in view of the varied goals for which students are preparing. A *minimal* degree of competence should not be too difficult to define in terms of the ultimate goal of preparing all students for research as well as practice.

5. *Students need the ability to present research findings in writing in such a way as to achieve effective communication both with psychologists and with other interested professional workers.* It was the general impression of the Conference participants that this need has not, as yet, been met.

THE DOCTORAL DISSERTATION

Research competence is acquired only by doing research. With this point of view in mind, the dissertation may be conceived of as the prime instrument in the research training of the student in clinical psychology. In this regard, the dissertation has special merits in that it presumably is independently formulated, executed, interpreted, and defended by the student.

However, certain possible weaknesses as a medium of research training are often apparent in the typical doctoral dissertation. It is usually a research task of formidable proportions designed in accordance with the most rigorous methodological standards, for which the student is often ill-prepared. Its execution is often attended by considerable anxiety, and the net result may be an extinction rather than a reinforcement of research drive. Step by step procedures may also be dictated by the adviser, in which case one wonders about the training values derived.

There is also grave danger that the multiplication of requirements, particularly in the technique courses, will result in an insufficient allowance of time for the dissertation.

Earlier sections of this chapter have dealt with methods for increasing the student's interest in research in the university setting.

The allied problem of determining topics suitable for dissertation work cannot be settled by a conference, since the ultimate validity of any study is dependent upon the research itself. General policies in regard to the possible limitation of dissertation topics were, however, discussed, with rather general agreement being reached on one question and considerable caution being displayed in regard to another.

There was unanimous agreement that clinical students should not be dictated to as regards the area of dissertation research—they should be free to choose any field of psychology. As a means of increasing the store of knowledge useful to clinical psychology, however, it was recommended that students be encouraged to tackle problems in the field of personality. If topics are chosen in other areas, advisers and departments should satisfy themselves that such topics are selected because of their real interest to the student and not solely as a means of mechanically meeting formal requirements. The resolution on this problem, which met with no opposition, reads as follows:

> The graduate student in clinical psychology may be permitted to do a dissertation in any field of psychology, but it is desirable and developmentally valuable for such research to be in the field of personality, broadly conceived.

Considerable caution was voiced over the suitability of the study of a single case as a dissertation. The group dealing with dissertation problems reported as follows:

> There is considerable doubt that a single case study, however carefully conceived and brilliantly executed, could satisfy the current requirements of a doctoral dissertation. However, this question deserves further study before a categorical denial of the suitability of this form of research enterprise is made.

When the Conference discussed this topic in a general session, the usual arguments pro and con found in the literature were presented. In essence, these seem to boil down to the following predicament: statistically reliable prediction *may* be obtained in analyzing the

data from a single case if appropriate variables are selected; but how can one be certain that such variables have general significance without testing them on at least one other person?

An objection was also raised in regard to current tendencies to explore *tests,* such as the Rorschach or Wechsler-Bellevue, to the detriment of exploring *personality.* Too frequently, it was stated, students select a question in regard to personality functioning and then apply as measures two or three of the tests that are currently popular. Greater contributions might be expected if investigations were based upon suitable methodology designed for the problem at hand.

When should the dissertation be undertaken? There is little doubt that the doctoral research will continue to be the closing phase of graduate work. Yet past experience testifies to the frequency with which dissertation plans are limited, to the detriment of the research problem, because the student has too long delayed active preparation for his study. In other cases, students may waste time up to months or even years because they fail to find a suitable topic following completion of the internship or the comprehensive examinations. The obvious solution seems to lie in an earlier selection of a topic and at least preliminary completion of a suitable design fairly early in graduate work, probably no later than the beginning of the third year. With this in mind, the following proposition was submitted to the Conference.

> The department should require early the tentative selection by the student of a research or thesis problem for which an adviser or advisory committee is appointed to give continuous advice and to follow up on the student's progress.

More than half of the participants were quite in favor of the resolution, but a sizeable minority expressed some disagreement. Objections were not directed at the principle of the resolution but were apparently due to questions of practicability and experience. The crowded curriculum allows little time for the student to plan the work required by a dissertation while he is also under pressure from course work or from an internship. Much of the maturing of

the student's interest and training takes place during the second and third years. The internship, if taken during the third year, may provide research ideas that would not have been contemplated if a thesis topic had been selected earlier. And, finally, research that actually makes a contribution is not the type of creative activity that follows a set time schedule. As an addendum to the last point, it was felt by some that certain students can be expected to select topics and plan designs early in graduate work, while others would fail to find topics until late in the training program.

In summary, the majority of participants approved the early selection of a dissertation problem. No one seriously disagreed with the general principle. A minority did object to the *requiring* of early topic selection, largely on the grounds that creative research demands maturity and insight, neither of which necessarily develops "early" in a graduate career.

Improving the Quality of Doctoral Research. There was obvious agreement throughout the Conference on the need for improving the quality of dissertations in clinical psychology. One way of accomplishing such an improvement lies in enlisting the support of psychologists, not necessarily in the clinical area, who are particularly competent in research analysis. This desire was embodied in the following resolution:

> In the planning and supervision of thesis research, the department should draw upon its full resources, particularly those staff members from the area of experimental psychology or those who have had the most experience in research and thesis supervision.

There was almost unanimous approval of this resolution. In discussion, a possible objection was voiced in the likelihood that persons unfamiliar with the problems of clinical research may apply unduly restrictive standards and discourage the student who is exploring a new area in which experimental niceties may not always be feasible. One can hardly quarrel with the need for fresh research in clinical psychology, and it is always possible that staff members in any area will fail to grasp the significance of many dissertations in embryo. Granting the above, it still was the opinion

of the Conference that nonclinicians should be drawn into clinical research whenever possible.

Another proposition aimed at improving dissertations was generally approved. It read:

> Both the objectives of the integration of knowledge and skills and of inculcation of research motivation and competence may be approached more effectively through the provision of:
> (1) Sufficient staff members, experienced in research and research supervision, to allow much personal contact with graduate students and
> (2) Sufficient space or other facilities to promote intra-student-group stimulation and criticism for the purpose of maturation and intellectual growth.

Creative research that embodies the scientific attitude rarely occurs in a desert. There seems to be no satisfactory substitute for personal interaction between student and student, and between students and instructors. The rapid growth of all institutions of higher learning following the second World War has increased the student-staff ratio and has also forced most departments into less and less satisfactory working quarters. At the graduate level where scholarship and research supposedly find their most fertile setting, the postwar deterioration in staff-student ratios and space assumes serious proportions. Undergraduate work in most universities has largely yielded to mass production methods. Technicians in psychology and most other sciences may be trained in the classroom. It is doubtful, however, whether many scientists of top quality can be expected to develop when provisions are not made for optimal personal interaction among students and faculty.

CHAPTER 9

Training for Psychotherapy

One of the distinctive characteristics of western culture of the mid-twentieth century is the generally accepted faith that psychological methods are available for the treatment of individuals with disordered personalities. This faith is in strong contrast to the conception of previous periods in history, which relied upon physiological or hereditary or religious explanations for mental disorder, and which held relatively little hope for accomplishing cures. Perhaps because of the undeniable successes in the physical and biological sciences rather than because of direct demonstration in the correction of maladjustment, modern society expects that those professionally competent in the field of interpersonal relations—the psychiatrist, the social worker, the psychologist—are capable of effective psychotherapy. Psychotherapy is, in the main, a valid and socially useful way of assisting people with personal problems. Yet the present picture is not so optimistic as the layman apparently believes.

The Need for Research. A sober assessment of present factual knowledge about psychotherapy inevitably points to the lack of definition in both theory and practice, the widely varying methods of training, the great differences in competence among persons recognized as capable of psychotherapy, and the tremendously divergent problems currently assumed to be treatable by means of psychotherapy. A somewhat facetious assessment of the present situation was given by one Conference participant who suggested, "Psychotherapy is an undefined technique applied to unspecified problems with unpredictable outcome. For this technique we recommend rigorous training." Although humorous chagrin may be

wholesome in reviewing the present status of the field, there is little humor in the manifest need for providing help to the large percentage of our population who could benefit by psychotherapeutic measures, inadequate though our present knowledge may be. With classic understatement, one sub-group reported: "The demands for psychotherapy exceed considerably the supply of competent persons. The opportunities for research are abundant."

When vast demand for a service is coupled with inadequate methods for satisfying the need, large numbers of self-styled experts grasp available opportunities and apply whatever techniques are at hand. Where problems of human welfare are involved, such irresponsible treatment must be condemned on ethical as well as practical grounds.

In the last few years, clinical psychologists have been offered rather unusual opportunities to participate in psychotherapy of all varieties. One of the most important questions faced by the Conference was the finding of adequate methods for training students in an area that offers so little scientific guidance, and that moreover inevitably involves the welfare and happiness of the persons being treated. Some truths can be expressed most briefly as platitudes. The following proposition was recognized as a platitude but one which, to a large extent, formed the keynote of the sessions devoted to psychotherapy.

> We recognize the need for vigorous research into the assumptions underlying training in psychotherapy and into the outcomes of therapeutic procedures.

As could well have been predicted, the conclusions regarding psychotherapy apply but slightly to specific techniques of training and practice. Instead of seeking specific applications, therefore, the Conference concentrated upon evolving a sound statement of basic policy that might help to resolve many of the present conflicting issues and yet encourage independent thinking and research in the interest of both human welfare and scientific knowledge.

Who should be trained for therapy? So far as psychology is concerned, the Conference agreed that:

> All students in doctoral programs in clinical psychology should have training in the theory and practice of psychotherapy even though many will not become therapists. This training is viewed as only an introduction to psychotherapy; true competence must depend upon supervised post-doctoral training.

As in other matters relating to the question of uniformity, the Conference was practically unanimous in its policy of striving for a high level of training while at the same time exploiting the advantages to be gained by recognizing the reality of individual differences among students. There was little argument over the proposition that psychotherapy is only one specialty in the field of clinical psychology. Not all students are personally qualified or will wish to practice it. Nonetheless, training programs should uniformly include work in psychotherapy so that all clinical psychologists will have at least a general background in the problems and techniques of the field. That a general background must be supplemented by intensive experience under supervision was explicitly provided for in the following statement:

> Except under unusual circumstances, it is expected that final competence in psychotherapy will be achieved at the post-doctoral level. There is a generally felt need for the development of better facilities than now exist for this more advanced kind of training.

Although it might appear that postponement of proficiency in therapy beyond the doctorate was merely a confession of inadequate training methods, the reasoning behind the decision is somewhat more complex. The Conference was most insistent on the need to train clinical psychologists on a broad basis of both science and practice. A four-year period is insufficient to allow for thorough grounding in general psychology, research methodology, and diagnostic procedures, as well as psychotherapy. There was no intention of devoting more time to the first three areas at the expense of treatment. Psychotherapy is a specialty involving risks and responsibilities; it cannot be trained for fully in one-fourth of a four-year curriculum. Psychiatry, which has pioneered and to a large extent provided whatever order there is in this field, requires a three-year

residency beyond the medical internship; in some psychoanalytic training centers a five-year period is required.

The need for post-doctoral training in clinical psychology is not limited to psychotherapy or to students now in training. No graduate or professional school expects to turn out a finished researcher, an accomplished practitioner, or a mature professor at the commencement ceremony. That special emphasis should be given to training in therapy is due primarily to the responsibility for doing meaningful research in psychotherapy as well as to the responsibilities involved in its practice. Post-doctoral training in psychology in areas other than therapy can ordinarily be obtained with little risk to clients or patients. The general problem of providing for post-doctoral training on an organized basis is discussed in Chapter 17.

How should psychotherapy be taught? In considering this question the Conference was forced to search for a working definition of psychotherapy. Agreement on a satisfactory definition has not yet been attained by workers in the field of psychotherapy. One participant reached the crux of many current issues in this statement: "Once psychotherapy is adequately defined and the psychological processes involved are understood, we can anticipate answers to the following questions: (1) who should practice psychotherapy? (2) how should students be trained?"

Admitting the present impossibility of arriving at a definite statement about the therapeutic process, the group nonetheless agreed to the following proposition as a working definition. (It was taken from the *1947 Report of the APA Committee on Training in Clinical Psychology.*)

> Psychotherapy is defined as a process involving interpersonal relationships between a therapist and one or more patients or clients by which the former employs psychological methods based on systematic knowledge of the human personality in attempting to improve the mental health of the latter.

A number of eyebrows were raised at the clause "based on systematic knowledge of the human personality"; but in a develop-

ing field of knowledge, pious hopes must sometimes fill gaps in acceptable theory.

Such a working definition suggested a number of questions about areas of application. Is vocational counseling therapy? Remedial education? Speech correction? Retraining of the physically handicapped? In view of currently divergent definitions in the literature and in practice, there was surprisingly unanimous agreement that the basic principles of psychotherapy are probably applicable over the entire field of psychological disturbance and defect. Their application may vary with the type of disturbance or defect presented, but the principles themselves should be fundamental in conception. Such a solution, of course, skirts the issues of whether persons engaged in vocational counseling or remedial reading should be qualified therapists in all areas and whether they should be called psychotherapists.

Narrow concentration upon a particular kind of therapy or a particular kind of problem was generally disapproved, although again the realities of training situations were recognized. Since intensive training in therapy is reserved for post-doctoral experience, time alone precludes from the Ph.D. program the (theoretically desirable) acquaintance with all types of therapy and with all types of cases. Certain universities are in a position to concentrate on particular approaches and to have their students become highly experienced with a limited type of case. Since breadth was felt to be desirable, equal emphasis can be placed upon developing in doctoral students an appreciation for various therapeutic approaches, some competently supervised experience, and indoctrination in the ethical responsibilities of the practicing therapist.

Conclusions in regard to general policies for training in psychotherapy were most clearly stated in the following proposition, which applies to all training in clinical psychology:

> Integrated courses which reflect the basic principles of psychodynamics, supplemented by adequate and carefully supervised experience in the practical clinical situations, are preferable to a series of single, discrete technical courses.

The practical implications of such a policy for training in therapy are readily apparent. The Conference disapproved of the frequent practice of offering course credits to students as a substitute for a carefully planned and organized *program* of training in therapy. Disapproved also was the practice of placing students in training agencies that engage in psychotherapy without previous attempts to expose the students to a series of supervised experiences, integrated with academic preparation.

Qualifications of Supervisors. While an attempt was made to specify the qualifications necessary for supervisors of therapy, the practical problems faced by many of the training universities make it improbable that such specifications can be stated otherwise than in terms of general competence. Clinical psychologists with extensive training in psychotherapy and capable of teaching at the graduate level are not plentiful. Psychiatrists and psychiatric social workers of recognized competence should be included in supervisory programs wherever possible. (This policy, of course, forms part of the more general need to integrate the training of clinical psychologists, psychiatrists, and psychiatric social workers.) That not all institutions are in a position to procure the services of competent personnel in other disciplines is a problem recognized by the other disciplines themselves. Thus the final recommendation in regard to such supervision can be stated only in terms of having supervisors who are themselves experienced in psychotherapy and are competent to train others.

There seemed to be general agreement that the need for research in and systematization of psychotherapy is as important as the need for training for practice. The domain of theory was felt to exceed that of actual practice, particularly where critical examination, general principles, and research are concerned. Such a statement in no way implies that patients or clients should be treated by unskilled persons, nor does it relieve the university of the responsibility for providing competent supervisors of therapy.

Self-Evaluation as Preparation for Psychotherapy. In some quarters a personal analysis or personal experience with psychotherapy has almost reached the point of being an ethical issue. Requiring all

clinical psychology students to have personal therapy is related to the broader question of whether a therapist can be competent if he has not had therapy himself. On this score there were considerable differences expressed, differences that were largely recognized as opinion. Individual differences among students make such a generalization difficult to establish. The general consensus seemed to be that the effectiveness of personal therapy as a prerequisite for its practice has not as yet been demonstrated. The Conference was generally sympathetic toward the notion of personal therapy but felt that as a requirement for therapeutic services we have as yet too little evidence to require personal analyses in the doctoral training program.

There was, however, considerable agreement that the entire training period should be utilized continuously as a means of developing self-awareness and self-evaluation. Experiences in self-evaluation can be made a part of training in the classroom as well as in supervised clinical work. Coursework in diagnosis may permit fewer opportunities for helping the student to examine his own attitudes; but such opportunities, coming ordinarily at the beginning of graduate work, should not be neglected.

Ethics in Psychotherapy. One chapter (Chapter 5) of this book is entirely devoted to the problem of professional ethics. Such problems loom largest, perhaps, where treatment is concerned. Here the Conference felt strongly that emphasis should be placed upon the following points:

1. Clinical psychologists, as well as students in training, should be aware of their own skills and levels of competence, since adequate preparation in one approach or with one type of problem does not necessarily signify competence in all areas of therapy.

2. Recognition of one's limitations is part of the therapist's ethical obligations to a client or patient.

3. Competence in therapy does not eliminate the need for collaboration with other specialists, but seems to intensify the realization of the need for referral and consultation when questions pertinent to the patient's welfare arise.

4. Students should not be permitted to engage in unsupervised psychotherapy.

5. Students should not be expected to render services beyond their level of training. This implies an obligation on the part of the university or training agency to evaluate carefully the competence of each student at each level of training.

6. The profession of clinical psychology has an ethical responsibility to the public to promote vigorous experimentation and research in various methods of psychotherapy as well as in training procedures for therapy.

Relations with Other Professions. One of the most perplexing and difficult questions in regard to training clinical psychologists in psychotherapy relates to the problem of interprofessional relationships, particularly with psychiatry and psychiatric social work. Chapter 13 deals with the general problems of interprofessional relations. The Conference paid particular attention to Report No. 10 (July, 1949) of the Group for the Advancement of Psychiatry, entitled "The Relation of Clinical Psychology to Psychiatry." Several members were present from the Group for the Advancement of Psychiatry Committee as well as from the APA Committee on the Relation of Psychology to Psychiatry, which had met with its counterpart committee of the American Psychiatric Association. Both sources indicated that relations between the two professions are undergoing considerable improvement and that in most local situations amicable working collaboration is in effect. However, many issues still remain as open questions, since the relative newness of clinical psychology as a profession has raised doubts of its adequacy in the clinical situation. There are even legal aspects, since the laws (as well as the professions) fail to define the limits of mental health or the methods of treatment that are controlled by law. Considerable confusion still remains on matters that call for definition. For example, the present Conference defined psychotherapy as applying to remedial work as well as to interview treatment of "sick" persons. The GAP Report No. 10 apparently differentiates between clinical psychology as a profession dealing with "counseling,

vocational guidance, and retraining" and as a profession related to psychiatry.

Private practice of psychotherapy by clinical psychologists raises other problems. Licensing, with its associated responsibilities, now exists in only one state, Kentucky. Psychiatrists and other medical workers are frequently reluctant for a number of reasons to accept unlicensed clinical psychologists as psychotherapists; their reasons include questions of competence, possible economic competition in the future, and the vital need in public and community agencies for a synchronized mental health team approach.

Especially noticeable at the Conference was a very sizeable group that argued against clinical psychologists' entering private practice. Their arguments were based on the need for post-doctoral training, especially in psychotherapy, the needs of agencies for clinical psychologists, and, finally, the difficulties in evaluating the competence of applicants for diplomate certification who have not spent several years in a recognized institution or agency. The issue of private practice is, of course, also related to the type of practice. Psychotherapy might be broadly defined to include all remediation, guidance, and treatment; would the same objections as those listed above be raised against someone specializing in private remedial work or counseling? Such questions will undoubtedly constitute one of the very important issues to be decided in the future.

Fortunately, it is in only a few areas that such confusion persists. In medical settings there is no question about medical responsibility. In other settings, the resolution, adopted by the Council of Representatives of the American Psychological Association at its Denver meeting in 1949, probably best represents the majority view of the participants at Boulder:

> We are opposed to the practice of psychotherapy (not to include remedial teaching, or vocational and educational counseling) by psychologists that does not meet conditions of genuine collaboration with physicians most qualified to deal with the borderline problems which occur (e.g., differential diagnosis, intercurrent organic disease, psychosomatic problems).

An alternate phrasing had been suggested in the GAP Report No. 10, in which collaboration with psychiatrists was recommended. The Conference heartily endorsed the basic principles outlined in that report but felt that the term "psychiatric safeguards" was at present too ill-defined to permit broad application in matters of policy. Instead, the Conference preferred a policy based upon the competence of collaborating physicians, pointing out that many areas in the United States possess few if any psychiatrists. In certain types of work, such as work with behavior-problem children, the number of qualified psychiatrists is exceedingly small; and pediatricians are taking an increased interest in psychological aspects of children's difficulties.

In essence there is little real difference among the conclusions reached. The GAP report, the APA Council action, and the conclusions arrived at by the Boulder Conference all emphasize the need for competence in relation to the ultimate goal of safeguarding the welfare of the individual client or patient. The apparent issue is an ethical one readily solved in principle. The underlying issues are vague matters of hesitating doubts and professional rivalries, which already seem to be well on the way to solution as the training of clinical psychologists undergoes steady improvement.

Illustrative of such trends is the report of an informal survey made by one sub-group at the Conference:

> In order to provide a basis for defining appropriate areas and determining the extent of activities of psychologists in psychotherapy, the sub-group attempted a survey of current practices as noted by members of the group. The following conditions were noted:
>
> a) With respect to types of patients treated by psychologists, the range is from persons with simple problems of adjustment to persons with major personality deviations, such as severe neuroses and psychoses.
>
> b) With respect to medical liaison, the range in practice is great. In some situations, psychologists are permitted to do therapy only under closest psychiatric supervision. In other situations, psychologists are doing psychotherapy independently, in liaison with physicians. In V.A. and state hospital internships, psychiatric supervision is the rule.

c) With respect to training, there appears to be an increasing willingness on the part of psychiatrists to assist in the training of psychologists as therapists, provided adequate safeguards are established.

d) With respect to attitudes of psychiatrists toward psychologists doing therapy, the range is from complete opposition to sympathetic support and active participation in supervision and training. In general, the trend appears to be toward the latter position.

CHAPTER 10

Field Training

A lengthy period of closely supervised, practical experience in the clinical situation has long been a recognized part of the training of the clinical psychologist. A decade ago, when formal training in clinical work was poorly organized, students were frequently advised to "take a year off and get a job and some practical experience" before completing the Ph.D. degree. Since the war, progress has been made in placing such training on a more formal basis, in which emphasis is placed upon utilizing the so-called "internship period" as a genuine *training* experience in which the student is offered a wide variety of experience rich in clinical material. Supervision by a well-trained clinical psychologist is generally accepted as a *sine qua non.* In many instances small salaries are paid for assistance rendered, and efforts are made to avoid exploitation in order that full advantage may be taken of the opportunities for training.

Types of Field Work. The Conference recognized a need to clarify the terms used to describe the various forms of psychological field work (or practicum) experiences. Three levels of experience are recognized by the APA Committee on Training in Clinical Psychology—laboratory experience, clerkships, and internships. Only the last two forms of experience can legitimately be considered acceptable field experience.

These experiences are all part of a continuum of developing responsibility and skill. Yet each type of experience involves objectives sufficiently distinctive to permit its consideration as a discrete step in an integrated training program. The major objective for each step in field work training is described below:

A. The *laboratory* experience serves the purpose of developing skills in a laboratory or pre-field-work setting for the primary purpose of developing a refinement in the use of basic tools and techniques. This should include practice in the role of participant observer as a first step in the teaching of the clinical attitude. Such experience, even though sometimes undertaken outside the university, is not for the purpose of teaching to the level of professional competence and responsibility.

B. The *clerkship* experience serves the following purposes:

1. Developing a feeling of responsibility for the client and a sensitivity to the clinician-client relationship.
2. Developing of minimal competence in the use of psychological techniques in a clinical setting.
3. Familiarization of students with a wider range of techniques.
4. Teaching of the nature and meaning of service.
5. Beginning of integration of university course content with the clinical viewpoint and with procedures in a service setting.
6. Introducing the interdisciplinary approach to clinical problems; learning to cooperate with colleagues of other disciplines.
7. Applying professional ethics.
8. Learning to communicate by the writing of case reports for clinical use.
9. Providing a wide range of clinical contacts at a relatively superficial level through a variety of clerkships.

C. The *internship* appears to be differentiated from the above in the following respects:

1. Supplying *intensive* and long-term clinical experience (especially through close follow-up of clinical courses).
2. Developing a degree of professional competence at a level comparable to that of junior staff member.
3. Providing intimate contact with clinical problems in which

the interne's activities have a bearing on the handling and disposition of a case.

4. Developing responsibility in the management of a case through semi-independent handling of psychological examination and treatment.
5. Developing confidence in operating in a service setting, particularly in the matter of assuming responsibility.
6. Establishing close working relationships with trainees and staff members of other professions by working intensively as a member of a clinical team; actual practice in the appreciation of the interdisciplinary approach to clinical problems.
7. Intensive training in the techniques of communicating clinical information to colleagues on the clinical team.
8. Imbuing the student with the spirit and values of the field institution.
9. A primary purpose of the internship is to provide a learning experience for the interne in a setting in which he contributes to service because competent and essential provision of service is one of the best contexts in which to learn.

Terminology of Field Work. One of the most persistent problems encountered at the Conference was the lack of agreement on terms used to denote particular kinds of field experience. The term "clerkship" has found little general acceptance as yet in clinical psychology, although it is in common use in medical schools. Most of the current confusion seems to arise over the word "internship," which at present is used to cover a variety of different types of experiences. In the V.A. cooperative training program, for example, some trainees spend up to half time on assignment to V.A. stations during their first calendar year as graduate students. Although their actual experiences during the first year are likely to be similar to those defined above under "Laboratory" and "Clerkship Training," the assignments are frequently referred to as "internships." In other instances, students may spend only half time in internship training

during their third and fourth graduate years, the other half being devoted to completion of university requirements.

To complicate matters, outside of psychology the word "internship" is most frequently encountered in medical training, although it is occasionally used to describe periods of practical training under supervision in non-medical areas, such as a year's "internship in a government agency" for students expecting to enter governmental employ. In its medical usage, however, it always applies to a period following the standard four years of medical school and usually comes after the awarding of the M.D. degree. Thus in some training hospitals, first- or second-year graduate students in clinical psychology as well as second-year post-doctoral M.D.'s are referred to as "interns."

Several participants at the Conference urged that the practice in clinical psychology be altered to conform to the medical usage. These participants also asked that a fifth year of required training be instituted, similar to that in medical programs, this fifth year being a formal internship following the awarding of the Ph.D. degree. While this motion received little support (most participants insisting upon the need for a *pre*-doctoral year of intensive experience and expressing a reluctance to extend the formal training beyond four years at the present time), there seemed to be a general consensus that the term "internship" was unfortunate and should not be applied to pre-doctoral training.

Therefore, the following resolution was submitted and approved by about two-thirds of those present; a sizeable minority was in disagreement.

> The term "practicum" should be used to designate pre-doctoral experience in clinical work on problems of actual clients or patients carried on under close and qualified professional supervision. Clinical work in a practicum should be done only after sufficient course and laboratory training has been given in clinical theory and methods to satisfy both the department staff and the field supervisor that the student is qualified for practicum work. The term "practicum" should be used to cover what has commonly been called "clerkship" and "internship."

The objections of the minority have considerable cogency. The word "practicum" in university parlance commonly designates any course that offers actual practice, even though it be carried out under laboratory conditions. Second, the minority argued that the word, in addition to being awkward, lacks sufficient meaning to cover the very intensive year's training in which the student, though under supervision, is nevertheless given considerable latitude in his work, and is hardly operating under "practice" conditions. There was apparently little objection to eliminating the term "internship," but rather a strong minority objection to assigning arbitrary definitions to words.

In summarizing the present situation, it would seem that the argument over the word "internship" is a matter for broader consideration and should be referred to whatever committee is designated by the American Psychological Association for arriving at suitable definitions of terminology in the field of clinical psychology. The Conference disliked the present use of the word "internship" and preferred to substitute "practicum." The objections of the minority indicated that strenuous disagreement is likely to arise on the grounds of general awkwardness, corruption of a now well-defined term, and general unsuitability.

Standards for Field Training. In the formulation and establishment of standards for the most suitable types of field experience, clinical psychology encounters one of its more pressing practical problems. Other professions have made considerable progress in this direction. In social work and psychiatric nursing, the training university and the institution or agency enter into a contract covering, in considerable detail, the types of training the agency will supply and the responsibilities of university and agency in the supervisory program. Post-doctoral medical internships are usually not supervised by the training medical school, but certain hospitals are certified by the American Medical Association as being suitable for such advanced training.

In clinical psychology, the very recency of formalized, intensive field work has precluded the establishment of generally-agreed-upon field work conditions. The problem became nationwide following

the second World War when universities plunged into the rapid establishment of programs in cooperating agencies and institutions. There has been a wholesale invasion of hospitals, public welfare institutions, clinics, and social agencies—in fact, all places where clinical material suitable for training students can be found. Institutions and agencies have generally been very cooperative in such undertakings despite the lack, in some instances, of immediate return for staff time and effort expended.

In spite of the very general cooperation experienced by the universities, shortages of trained supervisory personnel in field work centers have often made placements a difficult problem. Even when budgets have permitted the employment of clinical psychologists by a hospital or agency, the positions have often gone unfilled because of the lack of applicants. As a result students have frequently been assigned to clinical field work without adequate supervision by members of their own profession. In still other agencies, a similar shortage of psychiatrists, psychiatric social workers, and nurses has existed, and suitable experiences with other members of the mental health team have not been possible.

In order to keep an already confused situation from deteriorating and reducing the quality of training in clinical psychology, the Boulder Conference recommended that:

> Since there is an immediate need for standards for internship agencies, we recommend that the American Psychological Association take steps to study the problem and to set up standards and procedures for evaluating internship training centers. It is obvious that this is a task which the individual universities cannot and should not undertake.*

Problems in Accrediting Field Work Agencies. There is little doubt that any committee engaged in establishing standards and in certifying agencies will have a difficult time. Completion of this task is probably a number of years in the future. In addition to the fact

* The Association's Committee on Training in Clinical Psychology prepared a report on Recommended Standards for Practicum Training of Clinical Psychologists which was approved by the Association at its annual meeting at State College, Pennsylvania, in September, 1950. The report was published in *The American Psychologist.*

that it has never been done before in clinical psychology, so that considerable pioneering will be necessary to set up procedures, there also seems to be a difference of opinion on what kind of field training experiences are most desirable.

Although the Committee on Training in Clinical Psychology's report on recommended standards for educational programs in clinical psychology was aimed, primarily, at helping graduate departments of universities to develop high standards of doctoral training, and although this report did not attempt to establish standards for practicum training, it did emphasize the kind of training that may be given by well staffed psychiatric agencies whose chief purposes are research and training. This emphasis was due to the fact that such centers were better equipped at that time to give adequate supervision. Well staffed psychiatric centers are not found throughout the country; furthermore all members of the Conference did not feel that such a center always provided the range of training deemed necessary in the programs of clinical psychology students.

The greatest difference of opinion seemed to occur over the final goals of training in clinical psychology. There was frequent but not unanimous agreement that clinical psychologists need not always work or even be trained entirely in a medical or psychiatric setting. Clinical practice with relatively "normal" individuals, in perhaps a school or university program, was stoutly defended as a legitimate type of employment. To be sure, medical or psychiatric collaboration was felt to be of great importance in such work, but the type of clients dealt with need not always be "sick" persons. This group argued strongly that field work entirely limited to a psychiatric setting is not necessarily the best type of preparation for work with normal people. Too often, long experience with abnormal patients results in an oversensitization to abnormality and an undersensitivity to the real problems encountered by the relatively normal person.

In the original wording of a proposition relating to standards for field training, there was reference to "close and continuous supervision by clinical psychologists, psychiatrists, and social workers" throughout the "internship" period. Following debate lasting over several days, a relatively satisfactory agreement was reached in re-

gard to the need for internship experience in a psychiatric setting. The following proposition was approved 60 to 10 during the last days of the Conference:

> It is the responsibility of the Department of Psychology to make for each student a substantial field placement in an agency in which adequate supervision is provided and in which the staff consists of qualified clinical psychologists, psychiatrists, and social workers.

How much or how long "substantial" is, was not defined. There is no doubt, however, that the spirit of the resolution recognizes the importance of an "internship" experience in a psychiatric setting where intensive experience with the psychiatrically "sick" can be obtained. Even those students planning work primarily in educational or vocational settings presumably cannot be excused from obtaining such experiences, even though another "substantial" portion of their field work is spent in school, vocational, or counseling settings.

Despite the clear-cut acknowledgment of the necessity for close supervision during the "internship" period, opinion was divided over the necessity for intensive supervision during all field work at the expense of limiting the student's acquaintance with clinical material. The following resolution found some agreement among forty of the participants, but was objected to by twenty-one:

> The choice of practicum agencies should be made primarily on the basis of the quality and amount of supervision available and secondarily on the basis of kinds of clinical experience.

The objections raised were certainly not directed against the principle of adequate supervision, but were based primarily on the need to restrict students during clerkships to well-qualified practicum agencies. Concretely, it was asked, should a student be kept from spending time in an institution for the mentally deficient if he has no opportunity for such contacts elsewhere? Most institutions of that sort employ few psychologists, few qualified psychiatrists, and fewer social workers. Perhaps the institution and the university can provide only a bare minimum of supervision; but it was felt by some that

the opportunities for such experience should not be neglected if there is proper assurance that the patients or clients will not be harmed by such field work. If such placements take an undue amount of the student's practicum experiences, exploitation of the student's services at the expense of his training is likely to occur.

Another related problem, not confined to the year of intensive experience, brought considerably more agreement. Considering field training as extending over the whole four-year period, although at different levels of competence and responsibility, there was a very evident desire on the part of the majority of participants to insure that students' experiences should not be limited to the hospital environment. There were strong objections to training programs that concentrated solely on mental patients, even though students were legitimately planning a career as "medical psychologists." Such students, it was recognized, could with profit spend all the "internship" period in intensive specialization in the psychology department of a mental hospital. Nonetheless, previous clerkships should insure their familiarity with the problems of children and with those of normal adults of both sexes. The problem, of course, is particularly acute with students in the V.A. training program, where the on-the-job work tends to be largely confined to male adults in hospitals or clinics. Although the planning of work with non-V.A. clients becomes difficult for such students, the Conference nonetheless agreed, with only three dissents, that:

> Field training should be so planned as to provide a variety of functions with persons of varied ages and socio-economic levels—including normal individuals, the maladjusted, and persons of various degrees of psychopathology. When specialization is desirable for particular students, the variety of clinical experience may be correspondingly reduced; but such specialization should not be given before the third-year level of training.

Thus on two issues the majority of the Conference was clearly in favor of encouraging the broad development of clinical psychology along lines that extend the field of practice from the frankly psychotic or mentally ill to the relatively normal clientele who need information, vocational counseling, and remedial work. Special-

ization in any of these less clearly-defined branches has now become an open issue that must be faced sooner or later. Here we are not concerned particularly with the problem of specialization but rather with the problems that such a broad approach to pre-doctoral training poses for any committee attempting to accredit agencies for field training. A few psychiatric centers can probably qualify immediately for most of the full range of field work. There are also a number of social agencies and even a few school systems that provide adequately supervised experience with a clientele representing all varieties of problems except the hospitalized psychotic. Though such facilities exist in the large metropolitan centers, they cannot always be found wherever accredited training universities are located.

One possible solution to the problem lies in sending students to one or another of the fully qualified centers for their "internship" work. Unfortunately, such a logical solution fails to take into consideration the fact that there are now at least a thousand graduate students who are or soon will be in need of a year's field work. Furthermore, even if the fully qualified centers were able to accommodate the large number of trainees, the problem of financing vast numbers of graduate students away from the universities must also be solved. Few graduate students can finance a four-year program of university training without some outside help. Pay for part-time work can usually be obtained in a university where the student is well known, but may be impossible to arrange in a distant institution where a student is serving an internship. Housing for married students with families creates an additional problem.

Although student finances received but little attention at the Conference, it must be emphasized that this problem is one of the most acute and worrisome of all those presented in the planning of a program in clinical psychology. The Veterans Administration, the United States Public Health Service, and now the Department of the Army are making it possible for well qualified students to pursue such training. If these government-sponsored programs undergo serious retrenchment in the future, the universities and the profession will be faced with a serious problem.

Organizing Field Work Placements. What are the relative responsibilities of the university and of the field work agency in the training of students? As mentioned above, the practice varies with different professions, and clinical psychology has had too little experience to establish clear-cut relationships. Since the so-called "internship" period is part of the pre-doctoral training program, the universities feel a sense of responsibility for the activities in such a program. On the other hand, certain of the longer-established internship centers have highly developed training programs that have been integrated with the work of the institution in which they are located. Should universities sending students to such centers exercise directing influence over the particular type of training given to their own students or should the center follow its own program independently?

In actuality the question is probably academic, since few university departments of psychology would raise questions about the programs of the widely recognized training centers. The problem becomes real when it is posed in regard to many of the newer field training centers that offer only a few of the opportunities provided by the centers of long standing. Since the question is intimately related to the problem of certifying or accrediting field work agencies, the solution probably lies in the standards that are set up in the future. Until that time, it is apparent that the program for the "internship" period must be worked out by mutual agreement between university and agency. The university cannot relinquish its responsibility for insuring adequate standards of training and a suitable range of experiences. The field work agency is not in a position, always, to offer all the experiences deemed advisable by the university, nor can it always devote as much time to the supervision of students as the university might desire. The solution undoubtedly lies in the raising of standards all along the line; but such a solution must wait, in many localities, until the supply of qualified clinical psychologists, psychiatrists, and psychiatric social workers meets the demands of service agencies.

At the second level of field work training, the clerkship, problems are somewhat more intense, as various participants at the Con-

ference testified. Representatives from field work agencies and institutions reported that universities sometimes make exorbitant demands upon the agency in terms of the teaching of tests and other techniques that might well be the province of the university laboratory courses. Universities, on the other hand, reported that they have frequently encountered the difficulty that some supervising psychologists in the agencies expect students to be finished clinicians or, more specifically, to be well versed in the tests or interpretative techniques favored by the agency psychologists. Obviously, such problems cannot be entirely solved, since they represent differences in personal viewpoints as well as difficulties arising from the practical situations in which the university and agency are separately involved.

On one point it was possible to reach fairly clear-cut agreement:

> The university department has the responsibility of teaching the administration, scoring, and elementary levels of interpretation of some tests for clinical use and of certifying to the practicum agency the student's readiness for clinical practicum use of such tests.

This clearly removes the agency from the responsibility of conducting clinical training from the ground up. It does not, however, release the university from all responsibility in supervision once the student has been certified as being capable of performing elementary clinical examinations. At the clerkship level, students spend only a day or two per week in a training agency, and the staff members receive relatively little help from the work of the students assigned to them. Anyone familiar with the intense pressures of clinical work in a service agency can realize the reluctance of their psychologists to take over the entire training responsibility from the university. Working out suitable divisions of responsibility again becomes a matter of negotiation between university and agency insofar as the details of the program are concerned.

Length and Arrangement of the Internship. The final resolution on the organization of the "internship" period represents a compromise that may be resolved at a future time when there has been

opportunity for careful review of intensive field training. The resolution reads:

> Field placements on the third- and fourth-year levels of training should be at least nine months of full-time work or eighteen months of half-time work, thus providing continuous contact with clinical cases under study or treatment.

Several participants objected to the nine-month period, expressing interest in a full calendar year, because of the wide variety of experiences and techniques to be mastered. It was agreed, however, that the internship should take place at some point during the last two years of graduate training. Another division of opinion occurred over whether it should be a full-time internship or half-time spread over two years. The case for a full-time period was based upon the arguments: that full-time internships were necessary to provide continuous, intensive experiences in the follow-up of patients; that such full-time training was required for the development of a sense of clinical responsibility; and that it permitted the student to take full advantage of the wide range of staff conferences, teaching seminars, and informal case discussions provided by the training center. Additional advantages suggested were that only through full-time work could the interne be accepted fully by the resident staff as a working member of the clinical team, and that this plan also avoids problems involved in the divided loyalties and changing roles that part-time work tends to force upon the student.

The advocates of the part-time internship stressed the need for continuing integration between university and field agency. Spreading the internship over two years takes advantage of the maturing process under way in the student. They also stressed the fact that, for clinical research, one year is generally too brief a period in which to formulate, develop, and complete a dissertation.

The compromise agreement rested, therefore, upon realization that both forms of internship should be available so that the one best adapted to the capabilities of the individual student can be selected.

Some mention should be made of discussion on the organization of the "internship" period on a rotational basis that would enable

the student to move from one type of case or from one agency to another after set periods of time. Such a program is, of course, implicit in the content of the section entitled "Problems in Accrediting Field Work Agencies." There it was seen that the Conference most definitely desired that students have experience with all types of clinical material. Furthermore, it is evident that in the usual internship there is a continuous progression from one type of case to another based upon the increasing capability of the student to handle more difficult cases. Such solutions, however, do not always provide as thorough training as might be desired. A basic dilemma exists (for which no adequate solution is visible at present): prolonged experience in each individual setting is necessary to develop a sense of responsibility and to permit the student to observe the clinical course of patients; yet a distribution of clinical experiences among an adequate number of settings is essential—time is insufficient for satisfactory accomplishment of both goals.

One suggestion given some consideration was that, since a children's agency, an out-patient neuropsychiatric clinic, and a hospital for psychotic adults seemed to represent indispensable areas of the training program, a student might profitably divide six months between two of them on a part-time basis and devote another six months full-time to the third. It was hoped that some universities might find opportunities for testing out such variant plans in order to provide the field with data on all types of training programs.

In conclusion, it should be pointed out that the organization and development of field training in clinical psychology has undergone very remarkable changes in the short period following the second World War. Both the universities and the training agencies have been subjecting their staff members to unduly heavy supervisory loads. Aside from the perplexing question of the amount of time to be spent in a psychiatric setting, the Conference found a remarkable degree of agreement on the need for a broad approach to field training. Also apparent was an intensive interest in encouraging well-thought-out experimentation to discover optimal methods of organizing field work experiences.

CHAPTER 11

Selection and Evaluation of Students

Since the second World War, which introduced so many drastic changes into the training of clinical psychologists, university departments of psychology have been subject to a frequently embarrassing problem. With an extremely large number of applicants applying for admission to graduate work in psychology, how does one select those students who are most likely to achieve the goals set by the training program? Despite the vast amount of work done on selection procedures during the past thirty years, there has been little secrecy about the difficulty of selecting on reasonably objective grounds those persons most suited for professional, scientific, or executive positions. Such work ordinarily involves a large number of complex capacities and skills in addition to sheer intellectual ability as measured by standardized scholastic aptitude tests. Personality characteristics such as ethical orientation, facility in interpersonal relations, and fundamental interest in the scientific or professional way of life have not, as yet, yielded very fully to objective analysis.

The ratio of applicants to available openings in graduate programs of clinical psychology is encouraging from the standpoint of the future of the profession, but it poses problems to the applicant and to the university alike. One informal survey at the Conference disclosed that graduate schools are admitting from one in ten to one in thirty of the persons applying. The most conservative guess would indicate that at present about one out of every ten students applying at approved universities is accepted for graduate training in clinical psychology.

Under these conditions it would seem almost pointless to imple-

ment the following resolution were it not for the fact that better publicizing of the requirements for clinical psychology may well serve to stave off many fruitless undergraduate preparations:

> A systematic effort should be made to inform undergraduate students of opportunities in the field of clinical psychology and of the requirements necessary to enter the field.

An undergraduate major in psychology may have three purposes: it may prepare the student for professional training in psychology; it may provide a field of concentration for persons desiring psychology for general cultural purposes; or it may prepare students to enter other, related professions, such as personnel work, law, or medicine. The sudden enrichment of opportunities in psychology, plus the postwar increase in economic benefits, has attracted large numbers of undergraduates, many of whom must necessarily be disappointed. It would seem that college counselors and other vocational agencies should be well informed not only of the opportunities in psychology but also of the difficulty of gaining admission to graduate schools. One way of emphasizing the problems encountered by the prospective candidate and of helping vocational counselors in their tasks would be the dissemination of information on the actual requirements usually expected of successful candidates as well as on the goals of training for clinical psychology.

On occasion, undergraduates have viewed clinical psychology as an easy path to becoming a psychiatrist without undergoing the rigors of the basic sciences and medical school preparation. Their discovery of the science requirements and research training deemed necessary by the training universities for clinical psychology often occurs too late for readjustment of their undergraduate programs into more suitable channels. Other undergraduates have viewed clinical psychology as a means of gratifying their consuming interest in humanitarian activities. Again the science and research requirements of the graduate schools have led to disillusionment. A third group of students have persevered in their hopes of entering the field of clinical psychology despite undergraduate records that are mediocre in quality. For a number of years to come, it would appear

that admission to an accredited graduate school in clinical psychology will require a distinctly superior undergraduate record. Excellence in undergraduate psychology courses without corresponding quality in other work undertaken has been found to be a relatively poor recommendation for successful completion of the Ph.D. degree.

Social Factors in Selection. The type of student now admitted to training will to a certain extent determine the future characteristics of the profession. With the Conference strongly on record as favoring the twin goals of research and practice in the training of clinical psychologists, there was very little disagreement with the following proposition:

> Because of the great need for research and new knowledge in clinical psychology, graduate schools should give preference in admittance to those students with strong theoretical and social motivations rather than to those with primarily economic motives.

In the meetings devoted to a consideration of professional ethics, it was pointed out that selection procedures would, to some extent, influence the kind of ethical problems the profession would continue to face. There was no necessary implication that persons with economic motives would provoke ethical problems. There was, however, considerable feeling that because of the large number of applicants graduate schools now have an opportunity to select the kinds of students the profession wishes to train.

It is inconceivable that all applicants for advanced degrees in clinical psychology would be admitted. Their very number would overwhelm the psychology departments of the country. In addition to the impossibility of admitting all applicants, there are further reasons for the development of satisfactory selection procedures.

Wholesale admission would of necessity result in wholesale eliminations. Clinical psychologists cannot be trained on a mass production basis. It was generally agreed at the Conference that the number of students in a training program must be limited by the number of staff members available for supervision of research and

for supervision of clinical training. The exact ratio will, of course, vary from university to university depending upon many factors.

Furthermore, the social waste involved in wholesale admissions is reason enough for curtailing such practices. At the end of the first year, the surviving candidates might well be a more highly qualified group than those remaining from careful but not infallible selection procedures. Although this might benefit the profession, the large number of students eliminated would have suffered a most discouraging defeat and wasted a number of years of preparation for a nonexistent goal.

A final reason for careful selection lies in the economic factor that attends the development of facilities in graduate or professional education. Most universities contribute a substantial part of the expense of graduate education over and above that paid by the student in tuition and fees. The already precarious financing of graduate education would become even more uncertain if selection procedures failed to provide a reasonably good group of candidates for advanced degrees.

Thus the Conference disapproved of admission policies that fail to take into account the welfare of students applying for work in clinical psychology. Efforts should be aimed at proper initial selection rather than later elimination of the unfit. Universities should eliminate students who are unable to meet the necessary standards of training, but initial selection efforts should largely obviate the need for such dismissals. Other problems in connection with elimination will be discussed in a later section of this chapter.

Apparently some state universities are handicapped by laws or regulations that compel them to accept all candidates who meet a minimum standard of high school or college achievement. Such laws rarely if ever apply to particular departments, almost never to graduate training programs. It was pointed out at the Conference that the Committee on Training in Clinical Psychology has sometimes been of assistance in strengthening psychology department requests for greater freedom in matters of admission and selection. It was recommended that departmental privileges in the selection of graduate students in psychology be used to the maximum.

Artificial barriers to the admission of well qualified students were vigorously condemned at the Conference. Each of the sub-groups in its report to the Conference stressed the need to eliminate such barriers. With but minor exceptions the following resolution was heartily concurred in:

> Graduate students in clinical psychology should be selected solely on the basis of reasonably determined aptitudes for education and practice in the profession, without regard for economic status, race, creed, or sex.

At present, economic status plays a smaller role than before the war in the selection of students because of the large number of stipends available for graduate subsidy in clinical psychology. Race and religion may still play some part in selection procedures, although an impartial survey of graduate students now in training would probably attest to the profession-wide interest in selecting students on the basis of ability rather than on any artificial basis. One experience rather frequently reported is the relative scarcity of well prepared Negroes to do work in clinical psychology. One university actually discriminates in favor of Negroes, since it serves a region in which there is considerable need for Negro professional personnel.

Oddly enough, sex discrimination seems to be the one barrier that still receives occasional public support. No one at the Conference intimated that women students were less capable than men students. The one point of objection to women seemed to rest upon the likelihood that they as a group tend to have shorter professional careers than men, largely because of the likelihood that marriage and children will interfere with their professional employment. The main objection to the above proposition was based on the contention that where there is a shortage of opportunities for training, the students selected should be those most likely to continue in a professional career. Such a position in regard to women students received little support from the Conference.

Selection Procedures. Considerable interest was expressed in a report by Dr. E. Lowell Kelly, Director of the University of Mich-

igan project on the Selection of Students for Graduate Training in Psychology, sponsored by the Veterans Administration. Only interim reports have been available to date, but on the basis of the data so far collected it would appear that most of the clinical procedures in common use for the selection of graduate students have relatively little value in prediction of academic achievement and clinical skills as measured by judgments of supervisors at the university and in the clinic, *once an initial selection is made that eliminates students who do not possess the necessary capacity for graduate work.* When completed, the Michigan study will undoubtedly be scrutinized most carefully for possible aids in the general selection process. To date, however, it would appear from that study that the appraisal of objective tests and records of students predicts success in graduate school work in clinical psychology as well as, if not better than, selection procedures involving projective techniques and interviews.

Selection procedures now in use were discussed by the subgroups, with rather general agreement on the following items:

1. *Undergraduate Marks:* Varied evidence indicates that undergraduate marks offer the most reliable single predictor of success in graduate and professional education. Such a conclusion refers to the marks received in all undergraduate work rather than to exceptionally good work in a single area such as undergraduate psychology courses.

2. *Interviews:* The results of one study indicate that impressions gained in personal interviews with prospective students may actually lower the validity of selection predictions. It was suggested that research on interviews of a projective nature might result in better correlations. The ordinary employment interview of the direct question-and-answer type is likely to reveal only those characteristics a student believes to be highly qualifying.

3. *Objective Tests:* No great confidence was expressed in any of the currently used objective tests of scholastic competence as differential predictors of success in graduate work. Nonetheless, such tests, it was pointed out, have considerable usefulness if a cutting score is used to indicate those applicants who fall below a

given level of test achievement, and if the test results are used in conjunction with other personnel records.

4. *Autobiographies:* There was divided sentiment on the use of autobiographies, although most participants apparently wanted some type of self-reporting from applicants. Autobiographies when submitted for selection purposes tend to be colored by the student's efforts to appear to the best advantage. Their subsequent value for training purposes thus becomes much reduced. One university reported that answers to such questions as "Where do you want to be in clinical psychology ten years from now? How do you evaluate your own assets and liabilities?" had proved useful in their selection work.

5. *Letters of Appraisal:* By common consent it was agreed that the term "letter of appraisal" should be substituted for the usual "letter of recommendation." Such letters have come to receive a rather low level of respect as application material, although several participants expressed the opinion that letters from colleagues whom they knew quite well were likely to be of considerable help. It was noted that a really thoughtful and accurate letter of appraisal takes a long time to write. It was also suggested that the unreliability of such letters is due to uncertainty on the part of the writer and a desire to avoid possible injustice to the candidate.

Problems Arising from Multiple Applications. Under present conditions of acceptance for graduate work in clinical psychology, any well informed student makes application at a number of graduate schools of his choice. This procedure is obviously expensive and time-consuming for both the applicants and the universities. Methods for avoiding such difficulties were discussed, but there appear to be no immediate prospects of relief. The obvious solution of having a central office that registers the official reports of tests, collects personnel data of a uniform nature, and forwards them to the universities designated by the student met with considerable approval in principle but seems to be difficult of achievement at the present time. Such a central office would require a considerable subsidy to maintain its activities on a nation-

wide basis. If present conditions continue for any length of time, it is very likely that funds for such a clearing house will be sought with considerable persistence.

As a direct outgrowth of the practice of multiple applications, there arise a number of problems that react to the confusion and detriment of both applicants and universities. Since universities do not announce their acceptances and appointments to stipends at the same time, successful applicants often wait until they have heard from all places to which they have applied before deciding upon a university. Such a procedure is obviously advantageous to some applicants, but it forces other applicants and universities to wait a considerable period of time before final acceptances are possible. Universities may, of course, put a two- or three-day time limit upon their initial notifications of acceptance, but such a procedure is sometimes unfair and may work to the disadvantage of the university. In medical education, the usual practices involve: (a) a central clearing house that sends out weekly lists of accepted students to all medical schools, and (b) a required deposit when a medical school decides to consider the application credentials.

There was very strong sentiment in favor of encouraging the university departments of psychology to agree upon a common date for announcing acceptances to graduate work in clinical psychology. No formal resolution was offered, but it is hoped that the American Psychological Association will take cognizance of the problem and arrange for deliberations aimed at finding a date agreeable to all universities.

Selection for Clinical Ability. Present methods of selection seem to insure a relatively competent group of students insofar as intellectual capacity for graduate work is concerned. Singling out students who will demonstrate unusual creative performances or who will obtain the highest level of scholarly accomplishment is a much less certain procedure. The most vexing problem in selection, however, seemed to be encountered in finding students who will develop the clinical skills required in diagnosis and treatment. The problem of selecting students who will later develop into good diagnosticians and psychotherapists seems to be a desirable research

problem of considerable magnitude. Studies now under way at the University of Michigan and the Menninger Foundation (both studies sponsored by the Veterans Administration) may be of considerable interest along this line.

The *1947 Report of the Committee on Training in Clinical Psychology* lists a number of logically defensible personality requirements in clinical candidates. Various participants at the Conference listed a number of others, but the general consensus seemed to be that the necessary qualities may not be discernible under ordinary conditions of observation.

On the negative side, participants reported certain traits that they had found from personal experience to be undesirable. Among these were rigidity and pronounced social prejudice. Also persons who had frequently switched from one course of study to another and those who seemed *excessively* concerned with helping people seemed to make poor clinicians.

Unwillingness to admit students who have failed in psychology in another university or who have failed in other professional programs seemed, to some participants, unduly harsh as a generalized policy. Considerable discussion on this point did not, of course, enable the Conference to arrive at any general conclusions. It was stated that student failures from other programs were poor risks in psychology. Others expressed a lack of certainty on this observation in view of personal acquaintance with graduate students who had failed at one university but who, after graduation from another, had become respected members of the profession. When entrance to training for most of the professions is so difficult to obtain, should a student be given a second opportunity after he has failed once? Inevitably the discussion turned to the problem of assessing risks in admitting students rather than operating on single factors. Finally, it became apparent that the power to admit students to graduate work is firmly held by the individual university and that such discussions as these serve primarily to acquaint psychology departments with the experiences and problems of other training centers.

Evaluation of Students. On the positive side the Conference

quickly settled the problem of providing guidance to students in training.

> Each department should establish the standards of clinical competence expected at each stage of training, and should maintain a continuous evaluation of students in regard to these standards.

Most department staffs hold quarterly or semiannual meetings to which members of the field training staff are invited for the purpose of discussing each student. Formal reports from field agencies are also considered desirable, and present sentiment seems to be in favor of developing a semi-standard reporting form for this purpose.

Ordinarily such evaluation requires but little staff time for the majority of students, if self-evaluation is made a continuous part of the training program. Students doing satisfactory or outstanding work are in the majority and they make themselves known early in their graduate careers.

Much more time is being spent on the small minority of students who do poor or borderline work. The question of when to eliminate such students is likely to be vexatious to both faculty and students—particularly when the student has developed close, if not dependent, ties to the department, or if he has a family and has had to buy a house in order to enroll for graduate training. Early elimination seems to be the most humanitarian solution and the least disquieting to all concerned.

The chief causes for separation reported at the Conference have been scholastic failure, lack of clinical aptitude, and personality deficiencies. The rate of separation, if V. A. trainee data can be taken as representative, seems to be in the neighborhood of 12 per cent of admissions, a figure closely approaching that of American medical schools.

Discussion of the mechanics of separation resulted in suggestion of two generally desirable procedures. First it was felt that when separation becomes essential the necessary decision and subsequent action should be taken by a responsible committee rather than an

individual faculty member. Such group action not only protects one staff member from bearing the brunt of student dissatisfaction, but also, by making it clear to the student that the action taken was a departmental rather than individual decision, increases the likelihood of his accepting it in the proper spirit. The second suggestion seems to be generally followed: students, when separated, should be given, wherever possible, guidance relative to their future vocational careers.

As a matter of possible future interest to the profession, it was mentioned that medical schools occasionally encounter persons who, having been dismissed from one medical school, secure forged credentials, or even change their names, and thus secure subsequent admission to another university. This problem does not seem to have arisen in clinical psychology but may require action if it does occur. One sub-group favored establishment of a central clearing house for such purposes, but the Conference voted it down for reasons discussed in Chapter 5.

Dismissal of students from training programs seems to loom largest as an uncomfortable personal problem rather than as an administrative matter of great import. One sub-group, recognizing the need to clarify such matters in order to maintain student morale, suggested:

> It is essential for the university to specify as precisely and explicitly as possible, the bases on which separation from the program shall be made. Those should be made known to all students early in their training. The bases should include: (a) inadequate academic progress; (b) unsatisfactory clinical competence as judged by department and service staffs; and (c) conduct not conforming to the ethics of the profession.

CHAPTER 12

Staff Training

The teaching function of clinical psychologists received relatively little detailed attention at the Conference. Its importance was not overlooked, but the Conference was primarily concerned with exploring policies and assessing the extent of agreement on basic issues in the training of clinical psychologists.

Since 75 per cent of the members of the Division of Clinical and Abnormal Psychology of the APA list teaching as their primary or secondary professional activity, there is every reason to encourage the interchange of opinion and practice in regard to specific teaching techniques. Occasional journal articles outlining practices in teaching a specific subject matter are valuable. Papers and demonstrations at conventions or local meetings are also helpful. Nonetheless, it was urged that more systematic methods should be devised to provide for the exchange of practices at all levels of clinical teaching. Special programs might well be arranged at American Psychological Association Conventions to stimulate interest in educational methods.

In addition to the need for discovering new and better methods of teaching clinical psychology, there is also an extensive demand for training of staff members in the techniques and subject matter that have appeared in the recent past, and which, for many teachers, have developed since their own graduate work. In-service training is a matter of concern to departmental administrators, university teachers, and service agencies. The next section discusses some of the pertinent problems and solutions raised in this connection, although the most comprehensive discussion of post-doctoral training is postponed to Chapter 17.

In-Service Training. Where clinical teaching is concerned, there seemed to be no opposition at the Conference to the proposition that "teachers of clinical psychology should maintain their clinical skills by continuing some clinical practice." Since the Conference set a double goal of research and practice for the training of clinical psychologists, it is only logical that those persons engaged in the teaching of clinical skills should also be constantly engaged in work of this sort. It was reported by many that using "live" case material not only is stimulating to the students of such an instructor, but also provides the instructor himself with frequent new problems and insights. At least one department has striven to formalize this necessary part of in-service training by providing, for each full-time teacher in the graduate program, a course load that routinely includes one large lecture course on basic subject matter, one seminar or other course with small enrollment on a subject in which the teacher is particularly interested, and one practicum course that provides continuous experience in actual clinical work. Variations of this arrangement can, of course, be worked out.

One of the very real problems involved in providing for continuous clinical practice lies in educating university administrations as well as psychology departments in regard to the time-consuming nature of clinical teaching. Accounting for time spent in clinical work and supervision is a difficult task. Nothing is more exasperating to the clinical psychologist in practice than to be forced to report his accomplishments in terms of the number of tests given or the number of interviews held. Any clever clinician can objectively demonstrate his devotion to duty by simple statistics and an adroit use of a few odd hours giving tests in rapid succession to persons who do not need them. Adding to this the number of outgoing and incoming telephone calls makes a very impressive report. When one is not only engaged in practice but also supervising students working on the same cases, the amount of time spent on a single individual or on one family may appear, to the administrator, fantastic. Discussing the interpretation of a Stanford-Binet or a Rorschach and integrating that interpretation with other clinical

data can in itself consume several hours, regardless of the level of training of the student. A single counseling or psychotherapeutic contact lasting but one hour may, and probably should, take at least another hour of discussion, especially if the student is to gain necessary insight into his own motivations during the counseling session.

Certain aspects of clinical training can be accomplished in groups; but inevitably a clinical teacher is faced with the necessity of spending a large amount of time with a small number of students if only to read and criticize their clinical reports. If administrations are not convinced of the necessity of allotting adequate time to such clinical instruction, the teacher either works himself to the point of exhaustion or devises simple methods for decreasing the quality of his instruction. If the instructor chooses the latter course, it is quite probable that his students will resort to similar survival devices. The welfare of the clients or patients dealt with under such conditions is not likely to be materially furthered.

In considering the expensiveness of clinical teaching, members of the Conference also expressed their interest in improving its efficiency. Case presentations often involve long periods of oral reporting, and might better be accomplished by the use of typed or duplicated reports. Staff conferences often wander aimlessly because sufficient attention has not been paid to preparation and organization. Instructors may struggle to correct unclear clinical reports without realizing that much education can be gained by returning the report to the student with the suggestion that he rewrite it in English. Laboratory or practicum testing may be carried beyond the point of profitable returns to student or client.

Other methods of promoting in-service training were discussed with particular reference to short-term institutes. The sabbatical year seems to have gone out of fashion, although occasionally some instructors can spend a full year at one or more institutions, obtaining experiences and exchanging ideas. Formal post-doctoral training is not yet organized in clinical psychology, but informal arrangements for the same purpose can be made with little difficulty. To facilitate the acquisition of special clinical skills, it was suggested

that some appropriate office or committee of the American Psychological Association maintain a register of those universities, clinics, and other agencies where post-doctoral training in various specialties might be obtained on a short- or long-term basis.

General approval was voiced regarding the suggestion that university staff members should also consider the possibilities of accepting full-time clinical positions for a limited period of time, possibly exchanging duties with the staff members whom they replace. Such exchanges may present practical problems, but the benefits obtained would be well worth the effort.

At the present time, the short-term institute of one or two weeks seems likely to provide the most feasible method of obtaining more formal in-service training. Such institutes have been attempted on a national basis during the past two or three years, often in connection with the annual psychological convention. Other institutes have been held under the sponsorship of a particular institution or university at which a recognized authority was invited to lecture and conduct discussions for a week or ten days. Institutes of the same sort might be arranged on a regional or local basis, taking on, in some instances, the organizational features of a club, and in others, those of group support of an invited lecturer.

In connection with institutes for in-service training, it should be noted that the Conference drew a sharp line between institutes that were arranged without reference to the composition of the participating groups and those specifying the qualifications necessary for enrollment. Considerable criticism was leveled at the practice of organizing small groups to learn a single technique regardless of the preparation or qualifications of the members. This practice has already produced for the profession certain difficulties involving persons who are "experts" in one particular technique but who lack adequate backgrounds in the general field of clinical psychology. Institutes that are limited to those with qualifications, either as accredited students or as qualified psychologists, constitute a legitimate method of disseminating skills and techniques.

Some Effects of Postwar Teacher Shortages. The lack of qualified teachers of clinical psychology following the war has made depart-

ments of psychology more acutely aware of the factors involved in good graduate teaching. The practice of having graduate students teach courses, usually on the technique level, was generally censured, although it was recognized that graduate students can make many worth-while contributions to the formal training program, particularly as laboratory or clinical assistants. Since, however, even technique courses should be taught with a broad theoretical and critical orientation, it was felt that all graduate courses should be given by a fully qualified staff member.

Such a conclusion raised another question directly related to teacher shortages. Since many universities and also service agencies have been forced to assign important teaching duties to staff members who have just received the doctorate, what can be done to improve teaching skills among the less experienced? This question was generalized further to include the more serious problem of the lack of attention paid to training graduate students in educational methods suitable for the level of teaching at which many of them expect to work. The widespread supposition that scholarly or clinical achievements automatically confer pedagogical proficiency was held to be a matter of wishful rather than realistic thinking.

Teaching at any level seems to require more than piecemeal presentation of a prescribed subject matter. Particularly at the graduate level, where education should aim for the development of critical and independent thinking, teaching skills are of singular importance.

According to Detlev W. Bronk, President of Johns Hopkins University,*

> Only the wisest of teachers discard the easy methods of didactic instruction to follow as counselors at the heels of students who freely satisfy their curiosity. Even in the scientific laboratory the student's curiosity is suppressed and the laboratory becomes a training ground for technical manipulation rather than a place for intellectual exploration. The present tendency to create an educational system which thus suppresses curiosity for the sake of "efficient" education robs modern civilization of the true scientists it needs.

* "Science and Humanity," *Science,* 1949, *109,* 477–482.

While one can not in all fairness expect graduate students to be trained to the level that Bronk suggests for good teachers, it would still seem but reasonable that graduate schools take some interest in the preparation of their students for future teaching duties. The Conference suggested that graduate institutions should assume more responsibility for instructing graduate students in teaching skills. Since clinical psychologists will often be expected to train persons in the allied professions as well as in their own, even those students entering service agencies could profit by course and practicum work designed to familiarize them with teaching methods.

Many universities provide informal opportunities for such training for students who are given appointments as teaching assistants during all or part of their graduate careers. Conferences held under staff supervision, in which teaching problems are discussed weekly, have in the past helped to disseminate throughout the profession of psychology a general acquaintance with good teaching methods. Since the war the great increase in the number of graduate students has decreased the likelihood that Ph.D.'s in this field will almost routinely have had teaching experience at some point during their graduate work. In the case of students in clinical psychology teaching experience is likely to be the exception rather than the rule, although there is a clear demand for many more competent teachers in this field.

The logical solution of establishing classes with course credit taught by persons qualified to impart instruction on teaching methods meets with a surprising amount of resistance, according to experiences reported by Conference participants. The graduate's possession of knowledge rather than his ability to impart it seems to be too often the criterion for deciding who should teach a course. In the light of any known relationship between the educational value of any given course and the credits assigned thereto, the Conference apparently preferred to be skeptical about the usual arguments against recognizing teaching as a respectable subject matter in the graduate school; and it suggested that the issue was important enough to merit formally organized course work with practicum wherever possible.

A final result of the teacher shortage and the related increase in the student-staff ratio has forced many departments to scrutinize the presuppositions concerning optimum class size. Research studies, mostly directed at the undergraduate level, have generally failed to find any significant differences in course grades related to size of class. In view of the many criticisms that can justifiably be directed against conclusions drawn from such data, particularly the one that class size makes no difference in educational efficiency, the Conference seemed to feel that the problem deserves much greater attention. It may well be that certain subject matter can be taught to large graduate classes without danger of lowering the level of instruction. On the other hand, too widespread use of large classes may militate against the development of those attitudes and skills which mark the finished scholar and the accomplished clinician. Both the amount of time required for supervision of clinical work and the desirability of close personal contact between teacher and student would seem to argue conclusively for maintaining small classes in the greater part of graduate instruction. Nonetheless, even more logical items of common sense have been cast aside as a result of empirical studies. The underlying factors in good instruction at the graduate level are too little known to warrant final decisions. Even in clinical instruction, the possibility of vastly improving graduate work by manipulating the amount of interaction among students was regarded by many as a subject worthy of investigation.

Therefore, the groups considering the improvement of clinical teaching suggested that since the optimum size of the group in clinical instruction has not been determined by research, studies on this problem should be undertaken, particularly in view of the differences of opinion regarding "group" versus "individual" methods in clinical instruction.

Evaluation of Instruction. Although there are many ways to evaluate teaching procedures, few of the approaches so far devised cast much light upon the effectiveness of teaching at the graduate level, where the acquisition of subject matter occupies a role almost secondary to the development of critical and creative thinking. Departments or committees can logically analyze the content of course

syllabi; theoretically, at least, objective measurement can be made of certain clinical skills, such as test administration and scoring. Yet the over-all effectiveness of teaching may be entirely overlooked if only these piecemeal techniques of evaluation are applied.

The Conference was particularly interested in the use of questionnaire appraisals obtained from students. Several participants reported that formal or informal questionnaires distributed to students had helped in course reorganization and the improvement of teaching methods.

One of the drawbacks to soliciting student evaluations lies in the possibility that the method may show popularity rather than proficiency of teachers. It was pointed out that students often are highly critical when first introduced to certain subjects or teaching methods, but after greater experience undergo a decided change of attitude. One suggestion was made that useful information might be obtained by having students evaluate their graduate school experiences several years after the awarding of the degree.

Another suggestion, which seemed to meet with considerable approval, was to include students on departmental committees and to invite representatives to attend staff conferences that are considering curricular and course organization. Participants who have had experiences with such procedures felt that students were generally useful members of committees, but that quite often the students were as badly split on major issues as were the permanent staff.

Teaching Aids. A need was expressed for better and more varied teaching aids. The following types of materials were thought to be of considerable usefulness in preparing students for clinical work:

1. *Verbatim sound recordings of clinical interviews and tests, illustrating particular techniques and characteristics of varied clinical groups:* There seems to be no reason why good sound recordings of this type could not be obtained in considerable quantity and made generally available on ordinary phonograph records. These could be used in class demonstrations, or students could, at their convenience, listen to them if adequate instructional material accompanied them. Several series suggested were: psychiatric examinations with various

diagnostic types; therapeutic interviews comparing different approaches; expert handling of difficult Rorschach administrations, particularly in regard to the inquiry; and play interviews with children. Motion-picture material with sound is apparently still too expensive to obtain and distribute, except for a limited number of topics.

2. *Typescripts of verbatim interviews, complete therapeutic series, and case histories:* The literature is remarkably devoid, with a few exceptions, of the raw data with which a clinician actually works. Written records may omit a good portion of the data obtained in the face-to-face situation, but staff and students both apparently find considerable interest in such materials. The University of Chicago Department of Psychology and Counseling Center has nondirective therapeutic interviews for sale, but this example has not been widely followed elsewhere.

3. *Significant plots for use in role-playing techniques in psychodrama:* Good plots are not easily discovered. Such materials with suggestions for their application should be published in the psychological journals and made generally available.

As an outcome of this discussion, it was proposed that the Division of Clinical and Abnormal Psychology sponsor the development of case materials suitable for analysis in clinical psychology courses. It was also urged that exploration be undertaken with new media involving a wide variety of cases.

A number of scattered suggestions were made in relation to staff problems which should at least be recorded for future discussions.

Although the principles of having clinical teachers maintain continuous clinical practice seems generally accepted, several participants expressed concern over the tendency of clinical staff members to isolate themselves, voluntarily or otherwise, from the general field of psychology. An opinion was expressed that such tendencies might be overcome by having the clinical staff teach occasional courses in nonclinical areas.

Departmental organization and operating procedures were also discussed briefly. There was a very general sentiment that democratic procedures were extremely helpful to morale, and that all

staff members should be consulted about matters pertaining to educational policy. Some felt that we have much to learn on this score and that graduate students should be exposed to problems of "administrative mental hygiene."

It was suggested that undergraduate courses in abnormal psychology or psychopathology might well be taught by experienced clinicians. This procedure would offer a realistic approach to the subject and might help to counter the frequent psychiatric criticism that such courses are of little use in pre-medical preparation, since they so often lack any contact with clinical material.

Finally, there was general agreement that at the present time there is considerable overemphasis on specific techniques, and that students are therefore likely to be helpless in situations where they cannot administer a favored test or apply a particular approach to a client or patient. Teachers should stress general principles and employ a wide variety of approaches to avoid the all-too-real possibility of turning out technicians in clinical practice rather than adaptable, professionally trained persons.

CHAPTER 13

Relations With Other Professions

Clinical psychologists are constantly operating in areas related to other professions, some of which have legal responsibilities, many of which operate through the sanctions of custom, and all of which may control in one fashion or another the extent and manner of the practice of clinical psychology or research activities. The Conference selected for particular discussion five major professions with which clinical psychology deals. These were: (1) psychiatry and other medical groups; (2) social work (with emphasis on the psychiatric social worker); (3) counseling and guidance; (4) school psychology; and (5) industrial psychology. The Conference was fortunate enough to have representatives from each of these professions in attendance throughout all sessions. One of the participants, a representative from psychiatric nursing, discussed this relatively new field during a general session. Relations with fields other than these were not included in the program because of time limitations.

Most of this chapter is organized around the reports of the groups that considered relationships with the five allied professions listed above. Concluding the chapter is a report submitted by the representative from psychiatric nursing.

The Conference gave explicit recognition and approval to the need for a multiprofessional approach to the problems of human welfare. The following resolution testifies to the importance of professional interrelationships in the modern world. It is not lip service to an abstract principle of the need for cooperation; it is, most decidedly, testimony to the imperative need for cooperative

attack upon problems of human welfare in the service of the individual. The following resolution was adopted without dissent:

> Because of the extreme complexity and variety of problems presented for assistance, and the equally wide variety of skills and techniques required for the most effective service to the individual, and in view of the fact that the current training in any one profession cannot possibly ensure mastery of all of these techniques, we urge clinical psychologists to adopt as a principle of practice the establishment and maintenance of active and effective liasion with members of allied professions in all service functions.

The adoption of such a policy has important implications for many aspects of clinical psychology. Training programs must, of necessity, incorporate material on the principles and practices of the allied professions. Chapter 10 emphasizes that the provision of needed opportunities to work in close contact with other professions is one of the major purposes of the clerkship and internship experiences. Chapter 5 suggests the importance of acquainting students with the ethical codes of the other groups. Various chapters emphasize the need to include members of the related professions in the academic and field training of the clinical psychologist. The establishment of interdisciplinary seminars, in which students and staff of allied professions participate, constitutes a recommended portion of the formal curriculum.

Thus the following resolution is no idle platitude, but a positive statement of a necessary procedure for implementing the more general policy embodied in the preceding resolution:

> Clinical psychologists should increase their contact with and information about the principles and practices of other professions that deal with personal and social problems.

Several times during the course of the Conference questions arose concerning the degree of relationship most desirable between clinical psychology and one or another of the allied professions. Clinical psychology first developed applied procedures in an educational setting. The psychological clinic of Lightner Witmer, established

more than fifty years ago at the University of Pennsylvania, directed its efforts to the "whole child" but concentrated largely upon educational problems. Clinical psychologists have always worked closely with social workers, particularly where children's problems were concerned, ever since the Stanford-Binet Psychological Examination established a rapid means for estimating the general potentialities of delinquent and neglected children. Of recent years the ties with psychiatry have become increasingly strong as the clinical psychologist has developed tools and concepts that have proven of some use in hospital or other medical settings. At the present time, certain clinical psychologists are very strongly identified with each of the three professions mentioned—education, social work, and psychiatry—and the concept of the "mental health team" has, despite numerous vicissitudes and lapses, played an important part in the training policies and practical applications of clinical psychology.

Such relationships are particularly likely to direct the orientation of certain psychologists toward one area of application or another. After considerable debate on the future orientation of clinical psychology as a whole, the majority of the group seemed to feel that in the clinical area, psychology could best serve the interests of the public by actively collaborating with all related professions, but at the same time maintaining its own position as an independent profession. This issue will probably be encountered again; further discussion of it is found in Chapter 17. At this point, it should be mentioned that such a decision adds to the difficulty of defining clinical psychology. The decision, if carried out in all respects, in reality continues the tradition of having some clinical psychologists interested primarily in children in educational or other settings, some devoting their time primarily to research, some highly trained and active in problems arising in medical settings, and some in each of the many related fields, such as remedial training, juvenile and adult delinquency, counseling, and vocational guidance. In the borderland between industrial or personnel psychology and clinical work, screening and selection procedures have often made use of clinical techniques and clinical psychologists in one fashion or another.

Work with groups of persons has been traditionally conceived to lie outside the clinical area. Nonetheless, as pointed out at the Conference, the clinical professions cannot ignore the vital questions pertaining to preventive mental hygiene or the problems posed by the large proportion of the population suffering from all degrees of maladjustment. Many impartial observers believe that the mental health professions will find it necessary to discover and develop procedures for applying clinical knowledge on a mass scale, just as medicine found that major improvements in the health of the population had to come from large-scale public health projects, which by now are recognized as essential aspects of any program for the prevention and control of physical disease. In any such ventures in the mental health field, all the related professions mentioned in the present discussion plus many others will inevitably be involved. Preventive mental health at the present time represents a shadowy hope rather than a field of knowledge. Its mass application, once useful principles have been discovered, may well represent one of the great challenges of the present era.

RELATIONS WITH PSYCHIATRY AND OTHER MEDICAL SPECIALTIES

In the past ten years, clinical psychologists have established ever closer working relationships with psychiatry and other medical specialties. Much of the friction that was anticipated on both sides seems to have disappeared as actual working relationships were established on the personal level. At the 1948 Convention of the American Psychological Association, a committee of the Division of Clinical and Abnormal Psychology reported orally that there was surprisingly little friction on the local level, where members of both professions would usually unite in the attempt to help the patient. Furthermore, the brief and unofficial survey (reported at the end of Chapter 9) of clinical psychologists' relations with psychiatrists and psychoanalysts indicates, as regards training in therapy, a considerable willingness on the part of the psychiatric profession to contribute to the training of clinical psychologists.

Relationships are not all perfect, but both professions have advanced to the point where representatives can meet amicably and discuss issues on a realistic basis. Dr. David Shakow, of the University of Illinois and the University of Chicago, published a comprehensive article in the April and July, 1949 issues of the *American Journal of Orthopsychiatry* entitled "Psychology and Psychiatry: A Dialogue." Shakow's use of the dialogue form permitted an extremely frank exposition of the issues at that time as they affected both professions. His keynote might well be found in his statement that most differences of opinion have arisen from "too many considerations based on the conscious and unconscious needs of the two professions and their professors, rather than on the needs of the patient or the fundamental needs of society."

Although differences between the professions of psychiatry and clinical psychology probably stem from multiple sources, a few of the differences are important enough to be singled out for special comment. Many of the present problems arise because the two professions deal with overlapping material—the maladjusted and the mentally ill—and because they also use some of the same methods—interviews, clinical appraisals, and psychotherapy. Each profession, however, has certain methods of its own, the psychologists being the almost exclusive employers of standardized tests, the psychiatrists being the only members of the mental health professions qualified to give and interpret medical examinations. The uncertainty resulting from overlapping functions and duties is aggravated by differing backgrounds and widely divergent training. Psychiatrists undergo many years of intense clinical training with people who are essentially sick, mentally or physically. Clinical psychologists have much less clinical experience with the mentally and physically ill during their training, although they do meet many more borderline cases as well as relatively "normal" children and adults. They also are broadly indoctrinated in the values and methods of nonclinical scientific investigation, values and methods that occasionally become opposed to the clinical orientation of the psychiatric practitioner.

To offset the divergences, the conference recommended two procedures in the form of general resolutions:

> There is an urgent need for accurate and comprehensive information concerning the various ways in which clinical psychologists are at present working in relation to psychiatrists and other physicians.

Such information would be invaluable in preparing a curriculum for clinical psychology training that would include material designed more specifically for training psychologists who are likely to work largely in a medical setting. Fifty-eight favorable votes were cast for the next resolution, with only five dissents:

> The training of the clinical psychologist *must include* supervised experience in a psychiatric center.

To clarify the implications of the two preceding resolutions, the following proposition was discussed over several days, and finally received a vote of 58 in favor, two opposed:

> While this group recognizes the great value of a substantial amount of training in a medical setting, this does not imply that the practice of clinical psychology should always be in medical settings.

It was agreed that functions overlapping those of psychiatry seldom cause misunderstandings in the area of research, and only occasionally in the area of diagnosis. It was pointed out, however, that the value of the psychologist's contribution to psychiatric handling of patients has been limited by three primary factors: the nature of the psychologist's tools; his cross-sectional approach to diagnosis; and his relatively short contact with the patient. To be sure, the psychologist is not necessarily confined to procedures that produce the above limitations, but in a hospital setting his functions sometimes have been circumscribed by a conventional diagnostic approach. This may have been as much the fault of the clinical psychologist as that of his colleagues in the medical profession.

In the field of psychotherapy, misunderstandings have arisen because of the relatively recent entrance of the psychologist into this area and a consequent feeling on the part of some psychiatrists that

psychologists have insufficient training, undeveloped ethical standards, and an inadequate feeling of responsibility for the patient. Report No. 10 of the Group for the Advancement of Psychiatry crystallized the doubts of psychiatrists over the welfare of the patient by referring to the necessity for "adequate psychiatric safeguards." Recognizing the need for serious consideration of this problem, the Boulder Conference voted 55 to 7 in favor of the following resolution:

> This group recognizes the need for the clarification of what constitute adequate psychiatric safeguards in the practice of psychotherapy by psychologists, and recommends to the Committee on Relations with Psychiatry of the American Psychological Association the exploration of this matter with the corresponding Committee on Clinical Psychology of the American Psychiatric Association.

The discussion regarding responsibility for the patient or client concluded that there are three types of responsibility: (1) *moral*—this is shared by all professional persons in contact with the patient; (2) *administrative*—in medical settings responsibility is ordinarily assigned to medical (often psychiatric) personnel, in educational centers an educator normally exercises this responsibility, and in psychological service centers, a psychologist is usually in charge; and (3) *legal*—while the legal responsibility of the medical profession is better understood and established than that of other professional groups, there are a number of situations and states in which legal responsibility is assigned to psychologists.

The exact roles that all clinical psychologists should play in relation to members of the psychiatric profession cannot, of course, be defined. Local circumstances, variations in training and competence, and even conditions of employment predetermine relationships in specific settings. In general, however, the Conference felt that a collaborative role, rather than one in which one profession is clearly subservient to the other, although the two are working intimately together, was in the best interests of the patient. A collaborative role has two necessary implications: (1) equality of status is recognized; but (2) it is recognized in the context of

differing fields of competence and responsibility. Joint discussion of the patient from admission to final disposition results in a more rounded view of the patient's problems and is conducive to better treatment. The collaborative role is extensively practiced within the medical profession when referrals are made from one physician to another. Here, there are commonly accepted procedures in which the question of status rarely enters, since there is explicit recognition of the limitations on both sides.

In collaborating with members of the psychiatric profession on psychiatric patients, it was agreed that a joint conference should formulate the questions that the psychologist would attempt to answer. However, it should be recognized that the psychologist, like the psychiatrist in his own field, is entitled to determine the specific psychological procedures relevant to working out the answers to the questions. The psychologist, with special training in these methods, is better able to serve the patient if given latitude to select the most useful procedures. For example, there are disadvantages as well as advantages to any of the current psychological testing procedures. These procedures are largely in the province of the psychologist. By asking questions, after a joint survey of the case material, the psychologist will have available all pertinent information and will, to a large extent, be able to exercise caution in the use of certain procedures that might have a traumatic effect upon certain patients.

Relations with Other Branches of Medicine. In addition to psychiatrists, psychologists are most likely to work with pediatricians, neuro-surgeons, neurologists, internists, and industrial physicians. The problem of the clinical psychologist functioning in a medical clinic that has no associated psychiatrist was discussed along with the more general question of whether psychologists should always associate themselves with psychiatrists. It was agreed that the most reliable safeguard for the patient was a high standard of training for all professions, with emphasis on the ability to recognize problems requiring referral and consultation. (Further discussion of this question can be found in the last section of Chapter 9.)

The possible contribution of the clinical psychologist to medical school instruction was discussed. It was agreed that it was necessary

for such a psychologist to be broadly grounded in psychiatry and organic disease, as well as psychology. It was pointed out that he should also be familiar with the goals of medical education and the operation of hospitals. The group felt that the psychologist could make contributions in the following ways: (1) by stressing psychological principles and sociological factors as they relate to problems of the medical patient; (2) by presenting developmental psychology in relation to problems that express themselves somatically; and (3) by contributing to courses already being given (e.g. teaching about mental deficiency in a course on pediatrics) rather than by teaching separate courses in psychology. The usual type of general psychology course work has met with a very cool reception in medical education. To be sure, many of the objections apply to psychology as it was taught twenty or thirty years ago, with extreme emphasis upon semiphilosophical and semi-neurological problems. Nonetheless, despite the advances in general psychology, the type of education preferred in the professional medical school demands a psychologist who is adaptable to the needs of the medical curriculum.

In the in-service education of physicians in hospitals, it was suggested that medical residents might rotate through the psychology department of the hospital, as is done in some psychiatric training centers, and that the psychological staff should make special efforts to discuss the psychological aspects of patients referred to them.

RELATIONS WITH COUNSELING AND GUIDANCE

During July of 1949, a conference on the training of personnel in the field of Counseling and Guidance was held at the University of Michigan, under the chairmanship of Dr. Edward Bordin. The Michigan Conference was also supported by the United States Public Health Service. Ten representatives of the Division of Counseling and Guidance, three clinical psychologists, and a representative from the National Institute of Mental Health attended. One of the major outcomes of these discussions seemed to be a common recognition that, at the Ph.D. level particularly, there was

much in common between the two fields. It was suggested at the Michigan Conference that the clinical psychology curriculum, with some additional emphasis upon problems of educational personnel, might serve for doctoral training in counseling and guidance. No decision was made on this suggestion, although it was to be discussed more completely at a later meeting of the group.

At the Boulder Conference, the same trend of thought became immediately apparent in the session devoted to a consideration of relations with counseling and guidance. The tremendous overlap in the curricula of both fields; the similarity of technique, theories, and goals; and the advantages of establishing a broad field of professional opportunity rather than finely segmented specialties were all advanced as reasons for concluding that the two fields might consider an eventual merger. Arguments to the contrary seem to center around the notion that individuals in the counseling and guidance field deal primarily with normal people, whereas the clinical psychologist deals with the abnormal. As far as the Conference was concerned, this contention seemed questionable, since the Conference, with only two opposing votes, agreed that clinical psychology is not necessarily practiced in a medical setting. The traditions of clinical psychology are perhaps as strongly rooted in work with school children and college students as they are in hospital procedures with the grossly disordered.

With this background, the Conference voted approval of the following proposition with only five dissenting votes:

> The American Psychological Association and its appropriate divisions should study the common and diverse problems and concepts in the fields of clinical psychology and counseling and guidance with a view to immediate interfield enrichment of knowledge and methods. Consideration should also be given to the possibility of eventual amalgamation of these two fields.

It was pointed out that while such an amalgamation would involve serious problems, consideration given in the near future to these problems might be highly desirable if eventual amalgamation is actually contemplated. There are already several groups with

entrenched interests on both sides. The American Board of Examiners in Professional Psychology is awarding a diploma in each field. There are two separate divisions in the American Psychological Association, although there is also a large overlap in membership. One suggestion was made that a "super" division of Clinical Psychology might be a solution, with subdivisions organized around special areas of interest and practice.

The marked similarities between the two fields led to considerable difficulty in defining the field of counseling and guidance as distinct from clinical psychology. The major differences brought out were as follows: (1) counseling and guidance workers usually deal with more limited objectives in educational and vocational adjustment, although the best guidance practice resembles the other mental health fields in advocating attention to the whole person; (2) the preparation of counselors includes course work in areas not always covered in clinical psychology programs, such as job analysis methods, occupational information, and educational principles, policies, and practices; (3) the present modal level of training in counseling seems to be one or two years of graduate study, although the Ph.D. and several years of experience are required for certification at the diplomate level; and (4) counselors rarely obtain much field experience with the psychiatrically ill, although they are expected to have considerable familiarity with the detection and referral of such cases.

The common core of both fields at higher levels of training seems to include: (1) a dynamically oriented psychology of personality; (2) basic techniques of measurement and research; and (3) interview and group methods of counseling or psychotherapy.

The group agreed that clinical psychologists can gain from contact with concepts and procedures in the counseling field, and that all clinical psychology students should have some experience in educational and vocational counseling. Such a recommendation does not unduly extend the training period, since in reality it helps to implement the Conference's resolution that students should have experience with normal people. More specific advantages to be found in closer contact would include: (1) a language of person-

ality description that deals with the normal; (2) attention to reality adjustment as well as to the so-called "deeper" areas of personality; and (3) attention to the intellectual, cognitive processes, which are often ignored because of our more recent emphasis on the conative and affective.

RELATIONS WITH SOCIAL WORK

As members of a subdivision of the broader field of social work, psychiatric social workers have been forging a separate tradition that gives them a prominent place in work with the mentally and emotionally disturbed. One of the more interesting paradoxes of the present field of mental health lies in the fact that although psychiatry, psychiatric social work, and clinical psychology represent three quite separate fields as regards tradition and training procedures, their actual clinical functions often show marked overlap; and their actual work in their routine activities in many clinics seems to be distinguished only by almost secondary functions of medical examination, case-history taking, and diagnostic testing.

Mr. George E. Levinrew, representing the American Association of Psychiatric Social Workers at the Conference, presented a statement comparing the professions of clinical psychology and psychiatric social work. This is presented in summarized form below:

> Social work has progressed from a volunteer service, with its workers trained outside universities, to a graduate, professional level; and research is included as part of its training programs. There is now a movement to train social workers to the doctoral level. The orientation of the social worker has always been service to people who have problems in social adjustment.
>
> Psychiatric social work is one of many social work fields. It is distinguished from the others by the fact that the psychiatric social worker has had a sequence of courses and field experience with psychiatric orientation, and works (eventually) in a psychiatric setting. The following tabulation presents on oversimplified but not inaccurate comparison of clinical psychology and psychiatric social work:

	Clinical Psychology	*Psychiatric Social Work*
Base setting	Psychology-Science-Research	Social case work
Tradition	Academic-Scientific	Service
Training (a)	Four years	Two years plus
Training (b)	Research and clinical	Interviewing, Case Material Recording, Supervision
Therapy practiced	Wide variety of treatment measures	Case work treatment in a psychiatric setting
Language	Conceptual	Concrete and related to "case material"

The major differences between the psychiatric social worker and the clinical psychologist seem to be highlighted by the differences in attitude displayed in the clinical setting. The psychiatric social worker is trained to accept assumptions about human behavior whereas the clinical psychologist is taught to question almost any assumption.

Such opposed attitudes could be expected to create frictions between the two groups in practical situations, although the experiences reported at the Conference contained little ground for believing that such friction is widespread. It would appear that psychologists in service positions generally agree that most service must be carried on using practical judgment rather than a questioning attitude. The psychologist must concede that the problems of real life rarely permit the suspended judgment that is the hallmark of the scientist. This means, essentially, that research in clinical settings must be adapted to the purposes of the agency or institution, although often the major policies of an agency can be modified without harming its work or its clients if the psychologist can demonstrate that he is engaged upon significant investigation, and if he can enlist the interest of his co-workers.

Further discussion of the psychologist's relation to social workers elicited three major criticisms that social workers frequently make in regard to psychologists: (1) the psychologist's attitude toward the patient is too often similar to his attitude toward a laboratory subject; (2) the psychologist on the mental health team is likely to play

the role of critic and thus create tensions in the team relationship; and (3) the broad field encompassed by the training program of the clinical psychologist creates a risk that he will be trained as a second-rate psychiatrist or second-rate social worker. Such criticisms, of course, are matters for serious inquiry rather than passionate denial, and might well be considered further for their value in planning the training programs of clinical psychologists.

Although no one denied the fact that the three criticisms cited above are quite familiar to those working in close relationship with the other two professions, several participants suggested that professional stereotypes often persist as a matter of cultural lag. As more and more psychologists with interests common to members of the other professions enter the clinical field, such stereotypes are likely to disappear much as did the picture of the low-heeled, suffragette social worker or the piercing-eyed Svengali of a psychiatrist. Nonetheless, the presence of such attitudes seems to argue for greater attempts to obtain training for clinical psychologists in centers that also engage in the training of psychiatric and other social workers.

The following recommendations were suggested by the Conference for consideration by the American Psychological Association's Committee on Relations with the Social Work Profession.

As a basis for insuring more satisfactory contact between the two professions, training staffs at the local level should work toward common understanding in regard to the following items:

1. Selection of students
2. Overlapping of clerkship and internship assignments with the field training of psychiatric social work students. Definite efforts should be made to assist the students of both groups to work together at times other than formal staff conferences
3. Possible routine assignment of clinical psychology students to social work departments in clinics or hospitals during periods of indoctrination into agency functions
4. Interdisciplinary seminars held at field stations
5. Overlapping courses and seminars, which could provide information and mutual training in interviewing, case work methods, community organizations, and community resources. (The excel-

lence of present methods of supervision of social work students in interviewing was frequently mentioned during the discussion)

PROFESSIONAL RELATIONS WITH EDUCATION

The public schools, colleges, and universities represent potentially fertile areas for research work in mental hygiene and applied psychology. As centers providing convenient aggregations of most age groups up to the adult, schools and colleges have long provided willing subjects for research in psychology. A course in educational psychology is usually required in teacher preparation. Counseling and guidance movements in the schools seem to be the present manifestation of a quarter of a century's use of standardized psychological and educational tests, although theories of progressive education have undoubtedly played another major role in that movement. Despite the opportunities presented and the many and varied contacts with applied psychology that the school offers, clinical psychologists at the present time are expending a relatively small proportion of their efforts in school settings.

The reasons behind the apparent lack of interest are partly semantic and partly economic. There is a separate division of School Psychology in the American Psychological Association, although the separation is more on the basis of sphere of activity and level of training than on the basis of differences in conceptual tools or matters of technique. In many school systems, the better-trained school psychologists are indistinguishable from the better-trained clinical psychologists except for the titles arbitrarily applied to them and the settings in which they work. Other differences may occur, of course, from the necessity of the school psychologist's having to develop particular familiarity with educational principles and procedures; but any applied psychologist is likely to take on some of the characteristics of the particular group with which he is working.

The economic factors are now more influential in bringing about the present separation than they were before the war, when salaries for school psychologists were not particularly out of line with salaries offered clinical psychologists in other activities. Furthermore,

universities are now pressing for training at the Ph.D. level and the public schools, at least, are rarely able to pay salaries commensurate with such training—except the large city school systems, the systems of more wealthy smaller communities (usually suburbs), and such combined school systems as those in the state of Pennsylvania, where each county is required to employ a school psychologist.

The picture of psychology in the schools is actually more complicated than the outline above would indicate. Educational psychologists with training in both disciplines are sometimes employed in schools. Counseling and guidance personnel may have been trained with particular emphasis on education, vocational counseling, general counseling, or clinical psychology. There is little doubt that the pattern of psychological service in the schools is going to remain confused for some time to come, although most training programs for school guidance work consider psychology courses to be part of their core curriculum.

The question of what can be done for mental health in the schools has a number of fairly well accepted answers. The following list indicates a number of ways in which psychologists have contributed to school programs:

1. *Training teachers in problems of mental health.* Present courses often leave much to be desired; for while they often provide teachers with general principles of personality and information about maladjustment, they fail to give the teacher real tools that he can use in his day-to-day handling of children or students.

2. *Providing counseling or psychotherapy for teachers as a means of in-service training and of improving the efficiency of classroom teaching.* One frequent objection to psychological or psychiatric service is its very great expense, if applied on an individual basis. By working with teachers, a large number of children could receive help inexpensively. The proportion of extreme deviates needing individual attention is relatively small.

3. *Diagnostic and treatment work with individual children.* Practices vary widely over the country. In some schools, diagnosis and treatment are accepted as part of the school's responsibilities;

in other systems, efforts are made to have all such work performed by community agencies or private practitioners. Psychiatric collaboration is a necessity, although in many areas the nearest psychiatrist may be more than a hundred miles away. Social workers are also indispensable collaborators in such services, and, in fact, may sometimes carry on such services as employees of the school.

4. *Curriculum consultation for several purposes.* (a) The curriculum as a means of forwarding mental health by including specific content or removing sources of tension from groups or individuals. (b) The curriculum from the standpoint of preferred educational procedures. (c) The curriculum from the standpoint of who shall teach particular subjects, or the relative effectiveness of particular personnel as a part of teacher evaluation.

5. *Consulting on the particular types of tests to be used in the school's testing program.* Such a service should demonstrate *how* tests can be used effectively and an educational program should be carried on to insure against their misuse.

6. *Acting as liaison with community agencies, courts, physicians, pediatricians,* and *psychiatrists.*

This list could be greatly extended; but even such an abbreviated list shows the possibilities for application of clinical psychology in the schools.

The training of persons for psychological work in the schools produced more questions than were answered. Other groups are considering the same problem, and much of their work is presently being coordinated by the United States Office of Education. There was divergence of opinion at the Conference on whether the core curriculum suggested for the clinical psychologist is the best type of training for the school psychologist. There was complete accord with the statement that the psychologist in the schools must have considerable background in educational principles and practices, although whether such background should be acquired by the earning of a teaching certificate (as required for employment in some states) or by supervised practical experience in a school service found no commonly accepted answer.

RELATIONS WITH INDUSTRIAL PSYCHOLOGY

The discussion of relations with industrial psychology was in no sense definitive, since there was no official spokesman for this group at the Conference, although a number of the participants had been active in that field. The sub-group that discussed this topic agreed that there is a common core in the training of both industrial and clinical psychologists, but also that each represents a specialization within psychology. Each has its specialized techniques and specialized applications. A clinical psychologist cannot expect to move directly from his own field into the industrial field without further training and indoctrination.

Within the industrial field there seems to be a need for two types of psychologists with quite different training. One is the psychologist with a major in industrial and a minor in clinical; the other is the one with a major in clinical and a minor in industrial. At the present time the manifest need is greater for the former but the latent need for clinically trained men also exists.

In general, clinical psychology is much more "client-oriented" than is industrial. As a consequence the clinical psychologist who works in the industrial field is frequently subjected to conflicts between his feelings of responsibility to the individual employee and his loyalty to the organization employing him. These conflicts are no different from those felt by any clinical psychologist who has some administrative responsibility or who works in a somewhat restrictive framework, but they are apt to be intensified in the industrial situation.

At the present time there are few, if any, industrial organizations having facilities that could be used for the field training of *clinical* psychologists. When such field training facilities are developed, they will probably provide opportunities for very effective internship experiences with relatively normal people.

PSYCHIATRIC NURSING

Miss Mary Schmitt, Acting Director, Department of Services to Schools of Nursing, National League of Nursing Education, was the

representative to the Conference from psychiatric nursing. Since many clinical psychologists have had little opportunity to come into contact with the rather new profession of psychiatric nursing, a report made to the Conference by Miss Schmitt is reproduced here:

> To my knowledge, this is the first time there has been an official exchange of ideas between the psychiatric nursing profession and a representative group of clinical psychologists. At the present time, nursing organizations are inviting psychologists to participate on an advisory basis. However, it is hoped that a continuing relationship may be set up in order to provide for the consideration of problems of mutual concern. At this stage, there seem to be common interests among the National League of Nursing Education, the National Organization for Public Health Nursing, and the Division of Clinical and Abnormal Psychology of the American Psychological Association. The American Nurses Association may be helpful in your current legislative activities. You may also wish to explore the functions of the National Nursing Accrediting Service, which came into being in January, 1949 and published the *Manual of Accrediting Educational Programs in Nursing,* July, 1949.
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> In keeping with the changing needs of society, the nursing profession engaged Esther Lucile Brown, Director of Studies, Russell Sage Foundation, to survey the profession of nursing. Her report, published in 1948, *Nursing for the Future,* describes the direction in which professional nursing is now going. In 1947, the general functions of the nurses were redefined, since we are now living in a society interested in maintaining and promoting health, a rapid development of health centers, and a recognition of the psychotherapeutic role of the nurse.
>
> Prior to the redefinition, nursing had begun to stress the importance of offering continuous nursing service (community to hospital to community). The basic professional nursing curricula are being completely reoriented in order to prepare nurses to meet the new developments in health service. More and more, the family is becoming the unit for service. Some of our students are progressing from experience with the healthy to work with the ill, and thence to the re-education and rehabilitation of those who have been ill.
>
> Within the above framework, advanced programs in psychiatric nursing and mental hygiene for graduate nurses are being developed. Advanced psychiatric nursing programs have been in existence since 1943; the mental health programs for public health nurses since 1947. Each of these programs leads to a Master's degree. Nurses so

trained are prepared to serve in many ways: to maintain and promote mental health; to prevent mental disorder; to provide remedial and curative care; and to promote re-education and rehabilitation. The accepted curricular objectives for all programs are the same, although the objectives of each are implemented in such ways as to train most effectively a nurse for each of the following goals: a teacher; a director of nursing service; a staff nurse; or a mental health consultant. The general objectives are to develop skills as follows:

1. Comprehensive understanding of the socio-psycho-dynamics of human (normal and abnormal) behavior and personality development.
2. Greater appreciation and understanding of social and cultural influence upon human adjustments and social interaction.
3. Increased understanding of self-motivation, which may be utilized in furthering nursing relationships.
4. Greater skill in utilizing nursing methods and an understanding of dynamics of behavior in assisting persons to modify behavior in a way that will promote health and prevent illness.
5. Greater understanding of the problems involved, and ability to plan, carry out, and direct comprehensive and continuous nursing care for and with persons in the hospital, or other community agencies, on state or federal levels.
6. Understanding of the contributions of members of the psychiatric team in preventing mental illness, providing remedial care, and rehabilitating persons, and the skill necessary in team cooperation.
7. Ability to teach psychiatric nursing and mental hygiene.
8. Moderate degree of skill in techniques and methods for investigating nursing problems and contributing to the body of knowledge of psychiatric nursing.

Those interested in developing professional training in clinical psychology may find it helpful to consult with deans or directors of schools of nursing in their own or other universities, since a number of professional nursing schools have been organized within the last ten years. There are evidently many problems common to the two professions insofar as the organization of professional schools is concerned.

An exchange of experiences between clinical psychologists and nurse educators in regard to length and variety of training for clinical practice and the evaluation of competence should prove to be mutually beneficial.

The dynamics of adjustment and personality development are now taught in nursing schools by dynamically oriented psychiatrists. It seems reasonable to believe that nursing will also turn to clinical psychology for additional help in such instruction, once clinical psychologists become available.

Psychiatric nursing, as a specialty, could probably advance more rapidly if collaborative research activities were undertaken with research-minded clinical psychologists. The literature contains very little in the way of suggestions for the psychological management of neurotic or psychotic patients during hospitalization. Such management is largely within the responsibility of the psychiatric nurse and varies in quality with the educational and professional experiences of the nurse.

Interdisciplinary seminars now form a part of some of the advanced programs in psychiatric nursing and mental hygiene. Both fields might well benefit by better relationships between nursing schools and psychology departments so that such seminars would stem from joint educational planning within the universities, as well as from joint planning with the Schools of Social Work and Medicine.

As clinical psychologists seek clinical experience for their students, it will be important for them to establish working relationships with hospital and clinic administrators and with nursing service directors, as well as with medical staffs. This may be especially advantageous in general hospitals where the staffs are not ordinarily familiar with the functions of the clinical psychologist.

Lastly, as clinical psychologists seek experience in community agencies, it should be borne in mind that well-baby clinics are largely under the direction of public health nurses. The same is true for the health supervision of the pre-school child.

The *American Journal of Nursing* and *Public Health Nursing* will provide good samples of present-day activities in nursing for those clinical psychologists who are interested in learning more about the profession of nursing as it affects their own training and practice.

Nursing as a whole, and more specifically, psychiatric nursing and psychiatrically prepared public health nurses, are looking forward to closer working relationships with clinical psychologists in the universities and in field agencies.

The Conference was impressed with the need for closer collaboration with psychiatric nurses. As Miss Schmitt pointed out, there are many ways in which the two professions are experiencing

the same organizational and educational problems, and many ways in which mutual explorations of common problems might benefit both professions as well as patients. It was recommended, therefore, that:

> An appropriate committee of the American Psychological Association should establish liaison with the profession of psychiatric nursing and explore methods for promoting closer understanding and mutual education.

CHAPTER 14

Relations With Government Agencies

In more ways than one, the second World War, the Federal Government, and to a lesser degree, state and local governments, have exerted tremendous influence upon the recent development of training programs in clinical psychology. The Conference at Boulder served as an opportunity for universities to take stock of these influences, since more than two years had elapsed between the inception of formal government programs and the convening of the Conference in August, 1949.

A brief review of the programs should start with the general effects of the G.I. Bill and its educational benefits for veterans. The advantages of this Act have been so widespread, and its administration has been so intelligently applied, that the Conference members apparently accepted it as a matter of course; only one mention of it occurs in the minutes of the meetings. True, the influence of the G.I. Bill is gradually diminishing as more and more graduate students use up their allotted time. Nonetheless, for the graduate students who have been enabled to begin, continue, and (often) complete their graduate education in clinical psychology, the G.I. Bill has been an uncelebrated event of vast professional importance.

The Results of Governmental Influences. Other federal programs for increasing the number of trained clinical psychologists originally met with a certain amount of suspicion, despite the fact that each was adopted by many universities. Both the program of the Veterans Administration to provide part-time employment for clinical psychology trainees (now numbering 700 students in 41 universities) and the training stipends and grants of the United States Public

Health Service were initially questioned for their possible coercive influence on training programs. The Department of the Army also announced in 1949 a program for subsidizing clinical psychology students during their last two years of graduate work. What can be said after a two-year period about the fear of federal coercion of education, a fear that traditionally has exercised such a widespread influence on American education? As far as clinical psychology is concerned, the following resolution, approved unanimously, seems to constitute an answer:

> Despite the deep-seated and recurrent fear on the part of the universities, domination by the Federal Government through financial coercion appears up to this point to be at a minimum. Federal agencies are to be commended for their sincere efforts to avoid coercion or domination of educational programs.

Lack of coercion does not mean lack of influence. Thus it was frankly recognized that federal programs have greatly influenced the field of clinical psychology, almost all such influence being on the credit side of the ledger. One sub-group reported that:

> Opportunities of great magnitude have been opened up by post-war developments in government agencies. These in combination with social need and professional readiness have produced an important effect upon the field of psychology.

Succinctly, the postwar influence of government has enabled universities to improve the quality of their training of clinical psychologists as well as to increase the number of their students. The typical training program is now a minimum of four years in length, rather than three as formerly. One year of internship is generally required prior to granting of the doctorate. But while these improvements have been possible largely because of the financial help of government programs, the actual directions and specific trends have been charted by the professional group itself as seen in the work of the American Psychological Association Committee on Training in Clinical Psychology.

Government Programs and the Future. Despite the widespread and freely spoken praise for the governmental programs as administered over the past two years, there was nonetheless considerable concern expressed over the need to maintain adequate standards in the future. There was no hesitation in recognizing that governmental programs exist in a political framework. Funds are appropriated by Congress and by state legislatures, whose complexions change from time to time. Budgets may be slashed arbitrarily and personnel levels may deteriorate. Since much of the current training of clinical psychologists is to some extent dependent upon federal grants to university departments and stipends to promising students, the following question was considered: "How can federal programs be kept at their present high level of administration and future domination avoided?"

The following suggestions were made:

1. University representatives should continue to serve as consultants to government agencies on relevant matters of policy. Such representation may not only increase the stability of federal support but will also enable training centers better to anticipate future trends.

2. Federally financed programs should continue to be conducted with adequate provision for cooperation between professional groups and federal personnel, and the practice of reaching important decisions on the basis of joint consideration by the profession and the government agencies should be maintained. At the request of participants from the public agencies present, this statement was further elaborated to remove any suspicion that the government agencies wish to control the policies of the training centers. Universities and government representatives agreed that the control of training programs is and should remain in the hands of the universities. It was emphasized that representatives from professional groups were necessary to the planning of governmental policies, but that representatives of government agencies should limit themselves to serving as consultants to universities and then only upon request for such assistance.

3. Clinical and other psychologists, as part of their responsibilities

both as citizens and as members of a profession, should take an active interest in federal programs in order to insure that such psychology programs are consistent with the best interests of the public and of the profession.

4. The universities and their staff members already exert considerable constructive influence on federal programs. It is important that this influence have the effect of helping the federal agencies to maintain their level of professional personnel by retaining competent persons now in responsible positions and by securing highly qualified persons for replacements and new appointments.

5. As a concrete example of interest in federal programs, universities can continue to encourage good students to consider government service for employment.

6. As one of the sciences, psychology should lend its influence to improving conditions for scientific workers in government service.

7. Public acknowledgment of the excellent cooperation between the government and professional centers can, in itself, help to maintain the federal programs on a high level.

In addition to means for maintaining federal support, the possibility of the withdrawal of such support in the future was discussed. This problem must be viewed in the light of current trends in the financing of higher education in general. Medical schools, for example, are experiencing almost disastrous increases in the cost of educating medical students. Private universities, even those with multi-million-dollar endowments, are not receiving incomes adequate to their needs. State universities, supported in the main by legislative appropriation, are finding their resources seriously impaired by increasing diversion of taxes into new responsibilities. Thus while the demand for scientific and professional workers is reaching new highs, and their education is becoming more expensive, financial support for training programs is increasingly more difficult to obtain.

While government programs have undoubtedly filled a great need in recent years, university administrators have not always been comfortable in accepting their financial aid. The federal budget is open to annual revision and state budgets are, for the most part,

appropriated biennially. Neither federal nor state agencies ordinarily can make commitments in advance of the period for which appropriations have been made. Thus universities frequently find themselves in the position of accepting much-needed financial support, but without assurances that long-range plans can be carried through or that personnel commitments made during periods of government support can be honored once support is withdrawn. Academic tenure, provided by the majority of universities, often creates special difficulties. Thus the Conference reaffirmed a plea for a principle that has been vigorously supported by individual training centers in their negotiations with government agencies:

> The principle of "forward financing" of training and research grants is wholly desirable from the standpoints of the universities and the profession.

The possibility of such forward financing is, of course, contingent upon Congressional action.

In view of the uncertainty of present government financing of training programs, the question of long-term planning was examined. Most of the universities represented have built their programs on a reasonable amount of local self-support. However, since many universities have increased teaching staffs on the basis of federal funds, some curtailment of staff and decrease in number of students would have to be undertaken if federal grants-in-aid were sharply diminished within the immediate future. The solution of the problem obviously lay outside the realm of the Conference. Nonetheless, in order to minimize the dangers of forced retrenchment, it was recommended that each university should assume responsibility for developing its own program with primary reliance upon local funds and local authority. Diversified training to meet the needs of local situations is one means of acquiring and retaining local support.

Thus while the Conference members were vocal in their approval of present federal programs, the problems of the future were seriously considered. Recommendations were made for avoiding trends toward government domination of training programs. The

financial difficulties of higher education were seen as important aspects of the development of training programs in clinical psychology. The need for maintaining local support of training programs was seen as a safeguard against sudden drops in federal grants. By maintaining strong local support, universities would be in a sound position to resist possible future encroachments upon self-determination. Finally, temporary grants from government can be used to develop new university programs which, after demonstrating their importance, can be taken over with local support when the grant is ended.

The V.A. Training Program. Since the training program of the Veterans Administration directly affects all 41 of the accredited universities with their 700 V.A. students, and approximately 130 consultants from departments of psychology, an examination was made of current practices in V.A. training as they affect the training universities.

Major concern was expressed over the question of the breadth of education of V.A. trainees. In view of the limiting of V.A. internships to hospitals and clinics working primarily with adult males, the question of advisability of specialization was debated. Although this topic is more thoroughly discussed in Chapter 3, some of the conclusions as they apply to V.A. trainees should be reported here.

There was general agreement that the training of V.A. students should be as broad as, and not essentially different from, the training of the non-V.A. clinical students. Among other things, this means that the training of all clinical students should include experience with a wide variety of agencies and with individuals of varying ages and types of problems. This point of view was heartily seconded by representatives of all government agencies, who pointed out that university training staffs have too often assumed that the requirements of jobs in the government demand training in techniques and content rather than in basic theory and methodology.

The selection of V.A. trainees seems to involve a major problem in the appointment of first-year trainees without previous experience in graduate work or clinical psychology. There was some sentiment

expressed for not appointing trainees until the end of the first graduate year in order that the student might devote full time to academic work during that year.

Greater integration of V.A. staff members with university training departments was felt to be desirable. There seems to be relatively little friction between stations and universities at the present time. Rival recruiting of staff members constitutes a problem, but there seems to be no need for action on this point since the difficulty is rapidly diminishing as graduates of the training programs become available. Improved understanding, greater integration of training, and improved morale of trainees can probably be brought about by providing academic appointments for qualified members of local V.A. staffs. This practice already seems to be fairly widespread.

Much discussion centered on the length of time being taken by current V.A. trainees in obtaining the doctorate. Since these students receive financial support only while working in a V.A. station, there is a strong tendency for them to spend at least half time obtaining practical experience. This, plus the need for experience in other settings, has resulted in the lengthening of their programs so that many trainees may not finish the degree in four years. In view of the fact that this problem is not confined to V.A. students alone, the group felt that current problems should be handled administratively and the issue of optimum length of training period should await further experience by training centers.

The United States Public Health Service Programs. There seemed to be few problems in connection with the utilization of the grants-in-aid and training stipends of the United States Public Health Service. The desirability of forward financing of such grants has been discussed above. While earlier notification of grants is certainly desirable from the universities' point of view, the Public Health Service must administer its program under federal regulations. It was also pointed out that from the standpoint of the Public Health Service, forward financing without assurance of future Congressional appropriations involves complication, since it may commit the agency to specific uses for all operating funds if appropriations decrease.

There was a discussion of the relationship of Public Health Service training stipends to teaching assistantships, scholarships, and the like provided by university funds. It was generally agreed that both kinds of help for graduate students can be well utilized by universities at this time. It was also indicated by the Public Health Service representatives that it is highly desirable for their stipends to be uniform in size at each level of training throughout the country, even though the size of teaching assistantships and scholarships provided from the universities' own funds may vary from one institution to another.

Other questions were raised concerning the flexible use of Public Health stipends. Should the university continue to request such stipends for the same students from year to year if their work continues to be satisfactory, or can the stipends be reassigned by transferring such students to non-Public Health appointments? The representatives from the Public Health Service in general favored a flexible use of the stipends if the universities so desired, but felt that it was the obligation of the universities to make their policies clear to students, so that false expectations might not be aroused. The question of fifth-year stipends and post-doctoral training was raised in connection with such stipends, but at present the topic seems to be an academic one. The Public Health Service has approved the general principle of supporting post-doctoral training in clinical psychology, but funds have so far not been available for this purpose, and the necessary policies for governing such training have not been finally determined.

The problem of including overhead in grants to university departments was discussed in connection with the issue of university finances. The Public Health Service grants cannot be considered as requests for contract training or research, but are attempts to help universities to meet their own objectives. The minimal overhead now allowed is to take care of incidentals, and should not be considered as a means of defraying all expenses involved in such grants.

An entire morning was devoted to the presentation of the programs of three federal agencies. Dr. Harold Hildreth, Chief of the

Clinical Psychology Section of the Veterans Administration, discussed current problems and future trends in the training program of his agency. Dr. Joseph Bobbitt, Chief Psychologist, National Institute of Mental Health of the United States Public Health Service, outlined the over-all policies of the Public Health Service in relation to the training and utilization of clinical psychologists.

Lt. Col. Charles Gersoni, Chief, Clinical Psychology Branch, Department of the Army, discussed the new training program the Army is establishing for the training of clinical psychologists for that service. Graduate students who have completed two years of work in clinical psychology (or psychophysiology) at an approved university, can apply to be commissioned as second lieutenants in the Army in order to complete the last two years of work for the Ph.D. degree. An internship year will be served at one of three Army general hospitals. Upon receipt of the doctor of philosophy degree, the graduates will be assigned to Army Medical Department activities as first lieutenants in the Regular Army.

CHAPTER 15

Accreditation of Training Universities

Any profession that attempts to organize its practices and policies is sooner or later faced with the problem of determining the procedures appropriate for training new members. This, in essence, was the broad task faced by the members of the Conference. Their agreements and disagreements are the basis for the present report. When a group of fundamental policies finds general acceptance, the profession inevitably is called upon to make public its program for safeguarding the interests of society and of aspirants hoping to qualify as members of the profession. Licensing and certification are methods for providing such safeguards, since they entail a public statement of the qualifications necessary to become a member of the professional group. In addition, these methods also control the use of professional status in a given state or locality.

Another method adopted by some professions is that of publicly certifying to the adequacy of training programs in particular training centers. This published approval is a highly limited type of professional recognition in that it certifies only to the adequacy of training facilities and makes no claim for the individual graduates of the accredited institution. Since the accrediting procedure must publicly endorse some training centers and, either explicitly or by simple failure to mention, exclude other training centers, accreditation at its inception normally may produce anxiety and resistance; for those centers excluded may suffer loss of status, of students, and of financial support. Few psychologists are likely to be concerned over protests from institutions proposing to undertake the training of clinical psychologists with obviously inadequate staffs and training facilities. Everyone recognizes, however, that honest differences

of opinion are bound to occur in regard to the borderline institutions that may form a sizeable proportion of the training centers being evaluated. The frictions that arise from such differences of opinion are intensified on both sides by the knowledge that lasting injustices may be perpetrated by a group sincerely trying to complete a necessary but largely thankless task.

One of the great dangers commonly recognized by those concerned with accreditation lies in the possibility of failing to provide channels whereby new training centers can establish themselves in the face of the inevitable handicap of not already being accredited. Instructors and students alike are justifiably reluctant to commit themselves to university programs that may not be accredited. Obtaining financial support for an "unrecognized" training program, whether from university or outside sources, requires a degree of salesmanship and pedagogical collateral that is, to say the least, rare.

An additional hazard of the accrediting procedure lies in the possibility that it may be used to safeguard, not the public and would-be candidates, but the accumulated privileges of dominant groups within the profession or among the already approved training centers. Competition for good candidates and deliberate restrictions on the number of new members entering a given occupation are not unknown. These are not necessarily reprehensible tactics in professional training; but when used for the benefit of entrenched interests and against the public welfare, such tactics must be condemned. Of more importance than condemnation, however, is the establishment of policies for preventing the occurrence of such abuses of accreditation.

In considering accreditation for university departments engaged in training clinical psychologists, an additional danger of considerable magnitude is encountered. Without exception, the training of clinical psychologists is only one part of the graduate training program of psychology departments. Graduate degrees are also awarded for concentration in research or in general psychology, industrial psychology, physiological psychology, social psychology, educational psychology, and so on. There is no necessary relation

between the department's adequacy in training for clinical psychology and its facilities for training in other areas of psychology. In fact, certain universities well recognized for their graduate training have preferred to concentrate their energies in nonclinical fields and have no program for clinical psychology. These facts of academic organization are well known to psychologists, but are likely to be unknown to members of related professional groups and may not even be clearly recognized by university administrators, now that universities have enrollments up to forty thousand students. How can one insure that approval of one portion of a university psychology department, clinical psychology, is not misinterpreted as approval of the whole department? The question, phrased in terms of clinical training programs that are *not* accredited, arouses even more possibilities of manifest injustice.

These major hazards of a program for accreditation were frankly faced at the Boulder Conference. To most participants it was (and is) a very serious problem, one that almost makes the accreditation question a choice between two evils, particularly when special circumstances surrounding the present training of clinical psychologists are considered. There has been a marked if not desperate shortage of qualified instructors in the field ever since the end of the war. To a large extent, most training programs in clinical psychology have been initiated or have been forced to undergo reorganization within the last three years. Add to these difficulties what was thought to be a lack of generally accepted goals and training methods, and the prospect for accreditation becomes even more bleak.

In spite of the very serious arguments against immediate accreditation, there seemed to be no real opposition at the Conference to the acceptance of accreditation in the future. What were some of the factors behind this acceptance?

In the first place, accreditation of training programs in clinical psychology had been going on for two years and was preceded by several years of preliminary investigation. The needs of the Veterans Administration and of the Public Health Service played a part in the start of this program. In 1946, the Veterans Administration

requested the American Psychological Association to provide a list of universities approved for the training of clinical psychologists. Also in 1946 the Public Health Service requested the American Psychological Association to recommend a suitable program of training for clinical psychologists. The *1947 Report of the APA Committee on Training in Clinical Psychology* (Appendix A) was a result, in part, of this request. The needs of the Veterans Administration for lists of approved training centers, and of the Public Health Service for all relevant information to assist staff and consultants in making the most effective allocation of training grant and stipend funds, have continued to emphasize the importance of the work of this APA Committee. The government agencies could not do for themselves what the American Psychological Association could do for them. Accordingly, the American Psychological Association, through the work of the Committee, evaluated university training programs in 1947, 1948, and 1949. Parts of the 1947 evaluations were published; the 1948 results were not published, because of actions taken by the APA Board of Directors, the Council of Representatives, and votes of university department chairmen. The 1949 results also were left unpublished.

It is thus apparent that self-evaluation by psychologists themselves became a necessity at a time thought by many to be inopportune. Yet at the same time still other forces were acting in the same direction to force consideration of accreditation.

Members of the American Psychological Association set up the American Board of Examiners in Professional Psychology in September, 1946, as a means of public certification for clinical psychologists, industrial psychologists, and counseling and guidance psychologists at the diplomate level. While ABEPP has no direct relationship to an accreditation program for training universities, the establishment of certification procedures by the psychological profession necessarily involves the problem of discriminating among certain institutions capable of engaging in the training of professional persons. Since clinical psychology is a profession that attracts many persons without adequate educational and personal qualifications, the problem of evaluating doctoral training programs

is perhaps more acute in the clinical area than in industrial or counseling and guidance psychology. Although ABEPP's establishment was one of the forces pushing toward accreditation, it should be noted that certification by ABEPP does not necessarily depend upon the awarding of the Ph.D. by one of the currently accredited universities.

Another impelling force toward accreditation stems from the very great influx of new students into the field of clinical psychology immediately after the second World War. The Conference believed that the profession of psychology has an ethical responsibility to answer as honestly as possible inquiries from students about centers where adequate training in clinical psychology can be obtained. To some extent, such requests for information may have resulted from the steps that had already been taken in accrediting. Nonetheless, the responsibility for providing such guidance is not dodged ordinarily even by those universities that have not been accredited.

A certain amount of hindsight was also available at the Conference, since accrediting had been in effect for two years. Each of the four sub-groups that considered accreditation problems reported favorably on the desirability of the procedure. One of the subgroups voted unanimously that "the general effects of the APA Committee on Training in Clinical Psychology appear to have been salutary." Standards have been raised; departments have scrutinized their programs and incorporated many improvements; and university administrations have become more aware of the problems of training clinical psychologists. Irritation at specific procedures and doubts of the omniscience of the Committee were freely expressed, but no sentiment to halt the accrediting of training programs in clinical psychology was discernible.

Publication of Ratings. Although accreditation has been under way for two years and was endorsed by the Conference, the problem of publication of the results remains an unsolved issue. This problem was discussed from all angles and over several sessions of the Conference. Suggested publication times ranged from "immediately" to "after 1952." Suggested forms of accreditation ranged from the

publication of a list with multiple categories, such as A, B, and C schools, to one list of approved schools only.

The discussion finally boiled down to two major principles with which the majority seemed to agree. First, the Conference should recommend that publication should *not* occur until the Committee on Training in Clinical Psychology feels confident that its ratings are adequate. Secondly, although the Committee was then in its third year of evaluating departments and sufficient confidence in its rating could be expected in the near future, the date of publication should be left for the Committee to decide. As a result of these decisions, the Conference framed a resolution that was submitted to the American Psychological Association and approved by the APA Council at the Denver meeting. The recommendation was as follows:

> Not earlier than 1950 and not later than 1952, two lists should be published: an alphabetical list of accredited departments without differentiation or classification; and a similar list of departments visited and regarded as in a promising stage of development.

Accrediting Policies. Earlier sections of this discussion reviewed many of the hazards in the evaluation of professional training programs. The Conference considered various methods for safeguarding the general development of professional training, and also individual universities, against the possible disadvantages arising from the evaluating procedure.

That accrediting is likely to crystallize the profession itself has been widely recognized by both friendly and unfriendly critics of recent accrediting moves. It is often pointed out that clinical psychology is a rapidly developing field that has sought real professional stature only in the postwar years. If formal and public approval is given too early to a particular type of training program, progress is very likely to be impeded, particularly if either the schools or the evaluating Committee hold slavishly to set principles of training. Conference members were very outspoken in recommending both to universities and to the Committee that university departments should feel free to experiment resolutely and to follow

their own convictions without adherence to either established objectives or published criteria. Although such public endorsement of the right of university departments to experiment with their programs is likely to increase the difficulties of any accrediting body, there can be little disagreement with the conviction that one of the major reasons for accrediting is to implement the desire of the profession to raise training standards as new and better methods of training become available. New and better methods are unlikely to be developed if the training universities do not feel free to engage in thoughtfully-worked-out programs that aim at better training, even if they depart from those conventionally approved. Conference participants who had served or were serving on the evaluating Committee felt that this policy has been explicitly accepted by the Committee during its deliberations.

The Conference also suggested that the Committee should routinely adopt two further procedures that might be difficult to administer, but that would help to insure objectivity in the rating process. The first procedure would make it incumbent upon the Committee to publish as explicitly as possible the criteria used in evaluating training departments. While no one suggested that matters pertaining to individual schools should be made public, the general policies upon which the Committee acts should be made available.

The second procedure suggested was that a discussion of the results of the evaluation made by visitors of the Committee on Training in Clinical Psychology should be made at the time of the visit when requested by department chairmen. This latter procedure is already being followed to a large extent, and letters to department chairmen from the committee contain the final conclusions of the Committee in regard to the individual department.

Since the present evaluating Committee is a creature of the American Psychological Association rather than of the training universities, the appeal from Committee ratings can be made to the Board of Directors of the Association itself. Nonetheless, many participants were concerned over the threefold functions now entrusted to the Committee. It decides on standards to be followed

in the accrediting process; it visits the training centers and decides on the ratings to be made for individual schools; and it provides advice to departments of psychology. To a large extent it acts as both judge and jury with only the right of appeal to the American Psychological Association and the influence of professional opinion as checks on its broad powers. While there was little criticism expressed of the way in which the Committee had exercised its powers to date, the problem of setting up policies that would help to insure the objectivity of its operations was discussed at considerable length.

The obvious solution to the problem would involve the creation of two committees with separate functions. One committee would set up standards for approving universities; the other committee would carry out the directions of the first. Experience has shown, however, that proliferation of committees is not the most efficient or the most workable method, nor does it necessarily insure objectivity. Communication between widely scattered members of a single committee is none too good even under the best conditions. Two groups with divided responsibilities might create more difficulties than would be solved. The problem is obviously one that requires considerable deliberation by psychologists in addition to those who were in attendance at the Conference. As a result of the discussion, the following resolution was decided upon:

> The APA Conference recommends that the APA consider the possible advantages of separating the two functions of establishing objectives and standards for training in psychology, on the one hand, and accreditation, on the other.

While the Conference felt that the question of separation of functions in accrediting schools was a matter to be decided by the American Psychological Association, there was general agreement that accreditation might well be given too much consideration at the expense of the even more important task of encouraging the profession in its efforts to review constantly its present educational procedures and to develop new and better ones. Accrediting committees almost always become engaged in practical matters that are

likely to limit their vision and focus their energies upon their immediate duties. Furthermore, the present Committee on Training in Clinical Psychology has no authority to accredit in fields of graduate training other than clinical, although its actions indirectly affect training programs outside of clinical psychology. Conference participants felt that the American Psychological Association should have a committee concerned primarily with *educational* policies, a committee that is not limited to the problems of *clinical* psychology but is in a position to evaluate the actions of accrediting committees as they relate to desirable educational principles. The following resolution, directed to the American Psychological Association, aims at the establishment of such a committee:

> We urge the creation of a committee with broad powers to examine and review educational philosophy, methods, and standards beyond those serving as the foundation for accreditation in any one field of applied psychology, and with the power to review accreditation policies and practices.

Many of the difficulties inherent in accrediting schools in clinical psychology remain for future decision. The especially irksome problem of having psychology departments as a whole known on the basis of their rating in clinical psychology alone found no ready solution at the Conference. One suggestion made was that the American Psychological Association again publish an up-to-date description of the areas of interest of each psychology department training graduate students. The interests and training facilities should be furnished by the departments themselves as was done in the 1947 report of the Sears Committee.*

One other matter that related to general policies of training was considered by a sub-group that discussed a medical orientation in regard to accreditation. This group felt that although in the past training in clinical psychology seems to have been particularly good in medically oriented schools, accreditation is not, and should not be, withheld because a school has another basic orientation.

* Sears, R. R., "Clinical training facilities," *The American Psychologist,* 1947, *2,* 199–205.

In summary, the Conference viewed accreditation in clinical psychology as a somewhat mixed blessing. Its establishment as a general policy seems to be an accepted fact. The procedural details are still in the process of development and will require thoughtful consideration by psychologists other than those on the Committee on Training in Clinical Psychology. There are many possible obstacles to be overcome, but frank recognition of the dangers, coupled with the development of reasonable safeguards, can avoid most of the anticipated problems.

CHAPTER 16

Licensing and Certification

Public recognition and control of the professions that affect the public welfare are an accepted practice. Recognition and control can be secured and exercised in various fashions, from licensing by a local or state government to certification by the professional group itself without legal recognition. The participants at the Boulder Conference were generally agreed that either licensing or certification will be an inevitable development in clinical and perhaps in other branches of applied psychology. Since, however, licensing or legal certification is most suitably carried out on a state-wide basis (although some large cities may also pass local ordinances to license or certify), psychologists will find it necessary to deal with separate state legislatures. Thus national conferences, such as the one held at Boulder, are most useful for the exchange of information and the formulation of over-all policies, which must later be interpreted in terms of state legislative procedures as well as in terms of the situation in the state psychological associations. Some states, because of strong pressures within them, seem to be rather badly in need of licensing or certification. In others, there seem to be few pressures of this kind.

Inasmuch as the questions pertaining to licensing and certification have occupied many groups within the American Psychological Association and its subdivisions for almost two decades, a considerable amount of information in regard to procedures has been collected in one form or another. The Conference was particularly fortunate in having present a member of the *Ad Hoc* Committee on Certification and Licensure of the American Psychological Association. That committee had worked out a preliminary statement of

proposed principles for the guidance of state societies in seeking licensing or certification. Since the committee's statement covers most of the important points ordinarily brought up in connection with this topic, the statement itself is reproduced below with the permission of the committee chairman. It should be pointed out that this is a preliminary report and that not all members of the *Ad Hoc* Committee are in complete agreement with all suggestions appearing in the statement.

AD HOC COMMITTEE ON CERTIFICATION AND LICENSURE
DRAFT STATEMENT OF PROPOSED PRINCIPLES
AUGUST 1, 1949

A. *Definition of Terms*

1. *Certification* as used in these statements is of two types: (a) mandatory, (b) voluntary.

2. *Mandatory certification* is the type required of the psychologist if he is to practice. The certification is by law or by regulation established under law and involves penalty on either the employer or the practitioner for violation. When the certificate involves permission for the public practice of psychology, it may be called a *license* to practice. A state school system may require a state certificate for one to practice psychology in the schools, but this would have no reference to the public practice of psychology. The school requirement, however, is a form of mandatory certification.

3. *Voluntary certification* is optional on the part of the psychologist. It is not required for practice by law or governmental regulation. A state society or a local society may issue certificates to members indicating a certain competence. The diploma of the American Board of Examiners in Professional Psychology is a voluntary certificate and is not required for practice.

B. *Principles*

1. *Voluntary certification* is recommended as a step that might well precede mandatory certification. A state society could establish such an arrangement. In Ohio, for example, the State Society has recently established an arrangement to award certificates. This step gives the society an opportunity to work out standards and have a unity of understanding, which is important when and if the problem of *mandatory certification* for public practice is proposed by the state association or by the legislature. This understanding can also be a guide in

dealing with the State Department of Education when standards for the practice of psychology in schools are under consideration.

In some states, however, *mandatory certification* is reported desirable at this time because: (a) there is obvious need to protect the public against malpractice, and (b) there is sufficient agreement among psychologists and members of allied professions concerning standards and practices in psychology.

2. Diplomate status in the American Board of Examiners in Professional Psychology should not be a requirement for either voluntary or mandatory certification in a state or locality. The American Board has emphasized that its diploma is not necessary for practice and does not represent the minimum qualifications for psychological practice. The diploma represents a professional distinction in a specialty.

While diplomate status should not be a requirement, it could be considered by a state board of examiners as a certain evidence of competence credited to the individual. This evidence might serve as a waiver of examination, but the state board should not surrender its prior right to determine the psychologist's standing as a representative of his profession in the community.

3. Certification, either voluntary or mandatory, should apply to psychologists and to psychological technicians.

Psychologists should be certified for general psychological competence and not certified for specialties. Thus there should be one certificate for psychologist and not separate certificates for clinical, industrial, and so forth.

In the case of the psychological technician,* however, certification should be on the basis of knowledge and skills in a specialty, and need not imply general psychological competence. The specialties may include test administration, statistical analysis, vocational interviewing, remedial speech, and others as the local needs may require.

4. Minimum qualifications for certification, voluntary or mandatory, should be as uniform as possible among the states.

5. Certification by a state society or by a state government requires a board of examiners made up of competent psychologists who shall conduct such examinations as may be necessary to determine the qualifications of the applicants. The board should number at least three and not more than nine.

In writing a law, provision should be made for the selection of board members that are representative of the profession. This might involve having the state society propose twice the number of nominees for

* Technicians in the clinical area would work under the supervision of a clinical psychologist, according to the thinking current at the Boulder Conference.

vacancies with appointment by the governor. Provision should be made also for removal of a board member for cause. This could involve the recommendation of the state society for action by the governor after appropriate hearings.

Provision should be in the law for adequate funds for the board to operate without being dependent upon biennial appropriations. The most obvious way is to earmark fees for the use of the board. Board members should be reimbursed for expenses incurred in performing their duties.

The Board should have the authority to set up its own regulations within the law after appropriate hearings.

6. It is recommended that the minimum standard for certification as a psychologist be the Ph.D. in psychology or its equivalent from an accredited college or university, and one year's pertinent experience. In inaugurating a certification procedure, persons with one year of graduate work in psychology and three years qualifying experience could be certified if applications were received within one year after the procedure is operative. Persons certified should not be in training.

It is recommended that the minimum standard for psychological technician be the Master's degree in psychology or its equivalent from an accredited college or university. Training should include an adequate supervised practicum in the specialty.

Persons should be either residents or in practice in a state at the time of application for either of the above classifications.

The foregoing standards for psychologist and psychological technician should also include the passing of an examination, as determined by an examining board. In inaugurating the certification procedure, the examining board should be permitted during the first year to waive the examination, if it deems wise, for certain well qualified candidates ("grandfather" clause). The examining board should also have the authority to determine eligibility of candidates to take examinations. The board should have the option of written or oral examinations or both. Fees collected from candidates should not be refundable; in this way the board will avoid the position of having financial support contingent upon favorable action.

It should be specified that it is the responsibility of the applicant to present positive evidence of moral and ethical standards and satisfactory training and experience. Thus the applicant must prove to the board his competence.

7. In writing legislation, the term "psychology" or "psychological technician" should be defined only in terms of the application of recognized psychological principles, not in terms of specified activities.

The former presumably reflect scientific progress and professional development; the latter may be superseded and may eventually impose obsoleteness on the profession.

8. Procedures should be provided in either mandatory or voluntary certification for reciprocity with other states having similar requirements.

9. In either mandatory or voluntary certification, procedure should be provided for revoking the certificate for improper practice, but making it possible for the certificate holder to appear to present his case. Provision also should be made for reinstatement of former certificate holders who are eligible. There should be provision to protect the board from damage suits.

10. In voluntary certification by a state society, provision should be made to require the certificate holder to remain in good standing in the association. This does not apply to compulsory certification.

11. In writing a law, it may be necessary, in view of prior certification arrangements, to exempt psychologists or psychological technicians from the provisions of the law, if they are employed in government agencies or accredited schools or colleges. The prior certification arrangements may be individual such as by state educational authority or by institution, as the accreditation of an instructional faculty.

12. A law should include a customary provision that nothing in its content should be construed as restricting the normal practices of any legally recognized profession.

Since the preliminary draft of the *Ad Hoc* Committee was available at the Conference, most of the discussion on legislation and certification centered about an exchange of information and discussion of the items appearing in the committee's statement. Both the desirability and the inevitability of eventual licensing were recognized by the Conference in the following resolution, to which there was only one dissenting vote:

> It is recommended that the American Psychological Association increase its efforts, through advisory services and financial support to state groups, in the furtherance of legislation for psychology.

Considerable attention was paid to the pressures toward licensing that are being felt, particularly among clinical psychologists. The title "psychologist" has never until recently had legal definition and

in most states it still does not. Any tea-leaf reader or palmist or phrenologist can claim and use the title with complete impunity. Many do. Thus in the public mind there is considerable confusion of the professionally trained clinical psychologist with the outright quack. Some of this confusion apparently exists in the minds of members of the allied professions who have had little or no contact with the trained psychologist. Much of the confusion is disappearing, but as clinical psychology as a profession gains public recognition, many individuals without professional training but with some smattering of the language lay claim to being psychologists and advertise themselves with that title. This group is likely to be even more troublesome than are the practitioners of the occult, since the public does not have great difficulty in evaluating the latter group for what they are. The public has little or no protection, however, against the untrained or unethical psychological practitioner, since identification of reputable psychologists can usually only be achieved by contact with state or local societies. In not all instances are these societies themselves certain.

Other groups working in the mental health field are also concerned with the need for licensing or recognizing publicly by some other means the clinical psychologist. The medical profession, and in particular the psychiatrists, are finding increasing use for the services of the psychologist; but at the same time many are somewhat fearful that lack of licensing leaves too much room for irresponsible practice. Licensing is thus a means of holding the psychologist responsible for his actions, in that withdrawal of the license prevents further work in that field. Licensing cannot insure ethical practices, but it can provide means for disciplining those who practice irresponsibly. Without licensing, there is literally no way of stopping anyone from such practice unless it can be proved that he is violating a medical practices act or some other law. Even then convictions are very difficult to obtain, since medical practices acts are of necessity extremely vague in the borderline areas of mental health.

Since the medical group is traditionally concerned with legislation affecting mental health as well as physical health, discussion

in one group centered on this point. From the experiences of various members of the group, it was learned that the American Medical Association has a committee interested in legislation pertaining to the related professions. When licensing acts for psychologists are proposed, the American Medical Association Committee usually wishes information from psychologists on the following points: (1) What is the extent of your practice and does it infringe upon medical functions? (2) Do you favor independent private practice? (3) What is your code of ethics? (4) Are you asking the state to give you responsibility for committing patients to institutions, e. g. the mentally deficient, the psychotic? (5) What are your training standards especially in the basic sciences?

Positive legal action, i. e. obtaining passage of a licensing act from a state legislature, has been found in several states to be an extremely difficult task. An act proposed by the state group may be so altered in the legislative committee that it becomes worse than no licensing act. It may also be modified beyond recognition on the floor of the legislature and then require strenuous efforts to quash it. Once passed, it is still possible for other acts to be passed that nullify what has already been accomplished. Furthermore, the problem of getting a proposed bill before a legislature or one of its committees is not always easy. Various groups, such as women's clubs or state medical societies, may be very helpful in such efforts, but a great deal of the work must be accomplished at the level of practical politics, which ordinarily means either securing the attention of some powerful political figure to sponsor the bill or getting the support of leaders in the legislature itself.

Where efforts are necessary for the suppression of restrictive legislation, organizations interested in public welfare—such as the National Federation of Women's Clubs, the American Nurses Association, the Junior Chamber of Commerce, or the labor unions —may be particularly helpful. It is usually much easier to suppress a proposed bill than to enact one.

The Conference seemed agreed that a note of caution should be injected into the present enthusiasm for licensing or certification. Someone has remarked that even if we do not have the benefits that

accrue from such public recognition, we also do not have to deal with the mistakes that may occur as a result of too hasty legal action. One of the sub-groups formulated the following statement:

> We counsel a policy of watchful and critical delay, which is not to be conceived as a desire to interfere with or impede legislation in states which feel ready and have satisfactorily worked out the complex relationships with other groups. While following this policy of evaluative waiting, we should be willing to take an active stand both against unethical behavior of members of our own group and against legislative proposals which would circumvent or prevent psychologists from functioning at the level of their greatest social usefulness.

CHAPTER 17

Current Issues in the Training of Clinical Psychologists

This final chapter represents an attempt to draw together those items of unfinished business which emerged from the two weeks of planned and unplanned discussions. None of these items were scheduled for a complete airing at the Conference although some of them occupied a good share of sub-group and general-session discussions. Some of them, such as post-doctoral training and the place of foreign language in the training program, represent fairly long-standing issues. In some, the solution was agreed to by a majority of the members of the Conference, but final achievement was impeded by practical matters outside the province of the group which met at Boulder. For other issues, there were pronounced differences of opinion among the participants as well as among many clinical psychologists not present at the Conference.

The items below are presented very briefly, without an attempt to discuss them exhaustively. Some discussion on each is to be found in other chapters of this report. It is hoped that assembling them into one chapter will give future conferences on a local or national basis a better opportunity to deal with them than was enjoyed by the group meeting at Boulder.

SPECIALIZATION WITHIN CLINICAL PSYCHOLOGY

The Conference seemed generally agreed that graduate students in clinical psychology should receive supervised training in clinical

work with many age levels and many kinds of clients and patients. Narrow specialization with particular age groups or in one kind of work, such as psychodiagnosis or psychotherapy, was felt to be unwise. Nonetheless, it was recognized that some students may legitimately plan to specialize in particular kinds of practice just as many will plan to specialize in certain research areas. For example, clinical work with children has many important relationships to clinical work in a mental hospital situation. However, each of these two fields does require specialized knowledge for maximum effectiveness of service and maximum fruitfulness in research. Furthermore, certain counseling fields require specialized backgrounds, just as remedial treatment with the physically disabled ordinarily demands experience that is not of importance in all areas of clinical psychology.

Although the participants at Boulder agreed on broad rather than specialized graduate training, this general policy does not solve entirely many of the practical questions that arise for students with particular goals or for departmental staffs that must constantly consider employment possibilities. Some specialization inevitably takes place in any graduate department, if only because of the interests of staff members and the nature of available training facilities. There are at present no generally recognized specialties within clinical psychology, except for the rather dubious distinction between work with children and work with adults. It seems probable that more clearly recognized sub-groupings will arise within clinical psychology at some time in the future. At that time, some stand must be taken on whether specialized training should be reserved entirely for post-doctoral years or should be encouraged as a part of the doctoral training program. (See also Chapter 3.)

PRIVATE PRACTICE BY CLINICAL PSYCHOLOGISTS

Up to the present time, private practice has been a relatively minor professional outlet for clinical psychologists. In some of the larger cities, particularly, some clinical psychologists have worked

without formal ties to any institution or agency. They have usually established relationships with physicians, with school systems, or with private agencies; but their work has been carried on independently. With the marked increase in the number of students in training and the fairly recent public recognition of clinical psychology as a profession, there is some tendency to believe that many more persons will, in the future, be attracted to private practice.

In some quarters, both within and without the profession, there is a marked tendency to discourage this trend. Among clinical psychologists themselves, there are feelings that the practice of clinical psychology requires very close working relationships with specialists in the allied professions in order that the patient or client may receive maximum benefits. Some persons also believe that the need for psychologists in agencies and institutions should take priority over private practice. Some members of the American Board of Examiners in Professional Psychology pointed out that adequate information required for certifying at the diplomate level is much more difficult to obtain in private practice than when a psychologist is working in an agency setting where his actual competence can be closely observed.

Outside the profession itself, the most important deterrent to private practice probably comes from the medical profession, which is apparently somewhat perturbed by the possibility that psychologists may infringe upon their field. Aside from the possible loss of income to members of the medical profession, there are fears that clinical psychologists are not adequately trained to practice independently. The private practice of psychotherapy seems to be a major bone of contention; for the treatment of the mentally ill has long been regarded as a medical field, and any attempt by persons who are not medically trained to engage in the private practice of psychotherapy with any type of patient or client is likely to be regarded as an infringement on the medical field. Many state medical practices acts are very strictly drawn, while in other states the laws are either ambiguous or nonexistent. The lack of licensing for clinical psychologists is frequently given as a reason for keeping psychologists from engaging in private practice.

Although the questions relating to private practice were frequently discussed at the Conference, no action was taken on this issue, since the meetings were largely devoted to problems of training and the group was not sufficiently representative of all those persons interested in the subject. However, the problem is one of considerable concern to all psychologists, and it will become one of major moment to the training centers if many of their graduates enter private practice. (See also Chapter 3.)

SUB-DOCTORAL TRAINING

The Conference recommended to the American Psychological Association that a survey be made of the need for persons trained in some aspects of clinical work at sub-doctoral levels. There were many questions raised about the effect of the common practice of training graduate students for one or two years, awarding them the M.A. degree and encouraging them to seek work as clinical psychologists. It was pointed out that this policy is to some extent offsetting the postwar effort to train clinical psychologists to a professional level where they can make maximum contributions to the mental health professions. Also, since sub-doctoral candidates can be trained in half the number of years of graduate work devoted to the Ph.D., many employment opportunities may be filled by partially trained persons, thus making it difficult for the increased professional standards to be put into effect.

On the other hand, it was argued that there is a definite need for persons with training at less than the doctoral level. Many agencies and institutions cannot afford to hire a full staff of Ph.D.'s, and under adequate supervision non-Ph.D. personnel can make a useful contribution. Other professional fields ordinarily have two or more levels of training in recognition of the fact that many types of work can be performed by persons with less than the full amount of professional training.

One solution, which the Conference approved in principle, was to regard sub-doctoral training as distinct from that of the Ph.D. programs and to recruit students specifically for one- or two-year

terminal training programs. Since, however, there seemed to be many questions concerning the actual need for and usefulness of persons at the sub-doctoral level, an intensive study of all factors in the situation was requested by the Conference. (See also Chapter 4.)

POST-DOCTORAL TRAINING

Although the last few years have seen tremendous advances in the training of clinical psychologists at the doctoral level, it now appears that demands are being made of the profession for persons with training beyond the Ph.D. degree. These demands will probably increase in the future. Four years of graduate training cannot cover in an adequate manner all the specialized skills and competences encompassed by the field of clinical psychology. Mature diagnostic ability and full competence in clinical research cannot be assumed as a general result of present doctoral training. Therapy can be presented only in an introductory manner. The present Ph.D. program can hopefully expect to produce sound psychologists who can increase their skills and competence through experience and self-training. For some psychologists, however, there is a need for formal training beyond the doctoral level.

How post-doctoral training should be conducted is not an easy question to answer, although major aspects of the problem can be pointed to quite readily. How many clinical psychologists should receive post-doctoral training? How long should such a program be? What kind of training should be envisaged? Under what auspices, single or in combination, should the training be presented? Final answers to these questions are not available; but some reasonable things can be said relative to each.

The proportion of clinical psychologists needing extensive post-doctoral training is uncertain. For many of the jobs that clinical psychologists perform, experience and frequent short-term training of a week or two will suffice to increase their knowledge, skill, and maturity. There are, however, some positions presently available, or sure to become available, for which a high degree of post-

doctoral training can easily be justified. First, there is an increasing demand for highly trained clinical psychologists on medical school staffs. These persons are required to teach medical students, to participate in research, and to act as consultants on clinical matters. Second, it appears reasonable to assume that each psychology department training clinical psychologists to the doctoral level could justify one post-doctorally trained person to direct the program or to provide finishing touches to candidates for the Ph.D. degree. Third, as the states develop preventive and outpatient mental health programs, they will need some psychologists trained beyond the doctoral level. Possibly only one such person may be needed in many states, but other states may need more than one. Fourth, the need for research in the mental health fields also indicates that some post-doctoral psychologists will be needed in this area. Finally, if clinical psychologists are to make a contribution to the demands for psychotherapy, it should be in terms of persons who have had adequate post-doctoral training in that field. Although the need for training beyond the doctorate cannot be stated in terms of number of persons, the items above should indicate roughly the magnitude of the training problem involved.

One cannot state with accuracy what the length of post-doctoral training should be. It would appear that serious training programs of this sort should represent a minimum of at least two years. For some persons, as many as three years could be justified. This problem will have to be answered by the experience gained with exploratory programs.

The kind of training needed cannot be described precisely at present. It seems clear that the offerings should be flexible, capable of being altered to meet the needs of individual trainees, since each person will probably want to specialize his training to some extent.

The auspices under which post-doctoral training are presented should probably be broader than those under which doctoral training is now given. No one psychology department is likely to have adequate facilities. It appears that the post-doctoral training center should have available at least the resources of one graduate school with a highly adequate department of psychology, a training center

for psychiatric residents, and good research facilities. For many trainees, access to a psychoanalytic training institute is likely to involve several cooperating institutions, which are likely to be found only in the large urban areas where multiple facilities are present.

Since organized post-doctoral training is not a reality today, the foregoing is largely a statement of the nature of the problems and some speculations concerning likely solutions. Although post-doctoral training in clinical psychology is sure to develop, it may not take place in accordance with what has been stated here. A small number of exploratory programs are needed so that experience will provide real and practical understandings. Finally, it should be made clear that with the widespread activity now encountered in the mental health field, all clinical psychologists can profit from short-term advanced and refresher training. (See also Chapter 4.)

TECHNIQUE COURSES AT THE UNDERGRADUATE LEVEL

It appears that most of the universities approved for training clinical psychologists are restricting their technique courses, such as diagnostic testing, counseling, and psychotherapy, to the graduate level. However, course work of this type is often taught elsewhere as part of an undergraduate concentration in "clinical psychology." The concrete nature of practical courses in testing and counseling often makes them a welcome relief from other courses aimed primarily at theory and research. The popularity of these courses makes it difficult for a department to exclude them from its undergraduate curriculum, particularly when it has enthusiastic staff members trained in clinical psychology and anxious to practice their arts.

While the Conference voted to restrict technique courses to the graduate level, it was unable to do more than recommend that this policy be put into effect. The question is one to be studied by the American Psychological Association, since it involves academic matters outside the province of clinical psychology. (See also Chapter 6.)

THE FOREIGN LANGUAGE REQUIREMENT

The results of the questionnaire circulated among Conference members illustrated clearly the marked divergence of opinion that exists among training universities in regard to the importance and place of the foreign language requirement in the graduate education of clinical psychologists. The desire to change the present modal requirement of a reading knowledge of two foreign languages was apparently held by most of the participants. None of the various possibilities presented seemed to attract majority support. The following alternatives were suggested at one time or another:

1. Eliminate the foreign language requirement altogether.
2. Require only one language and substitute skill in another tool subject such as statistics.
3. Require only one language but provide that it be learned to the point of mastery so that it could be a usable and dependable skill.
4. Require proficiency in one or two languages as an admission requirement for graduate work in clinical psychology.
5. Abolish the language requirement as it now stands but encourage those students with particularly good language aptitude to master several related tongues, thus insuring that at least some members of the profession would have access to material in foreign publications.

It should be noted that Alternatives 2 and 3 above are already being followed in some universities. (See also Chapter 6.)

THE CLINICAL PSYCHOLOGIST AS SCIENTIST AND PRACTITIONER

Despite the fact that the Conference as a group seemed fairly well content with the dual goals of scientist and practitioner in the training of clinical psychologists, some unsettled questions remain about the ultimate effectiveness of this general policy. Certain participants wished to stress one role at the expense of the other. There seem to be a number of logical conflicts involved in persons'

playing such a double role. One conflict that has been observed is the frustration of the research-oriented clinical psychologist who feels he spends and must spend an undue amount of time in service work at the expense of research. Another conflict that sometimes arises is that of the strongly research-indoctrinated psychologist who works with a mental health team made up of almost entirely service-oriented members from several professions. The psychologist's efforts to do research may make him suspect by the other members of the staff, who sometimes feel that his research interests endanger the welfare of the patients being served. Finally, there are differences of opinion on whether there is enough time in a four-year curriculum to train clinical psychologists adequately in both research methods and service without lowering the quality of both.

Further experience with graduates of training programs that stress both service and research will probably be necessary before these fundamental questions can be answered. (See also Chapter 8.)

ESTABLISHING STANDARDS FOR FIELD WORK TRAINING AGENCIES

The Conference was generally agreed that there is a need for the establishment of standards for those agencies and institutions which participate in the graduate training of clinical psychologists. Of perhaps greatest importance in this respect is the need for providing minimal standards for agencies that are used particularly for internship training at the third- or fourth-year level. It was hoped that the American Psychological Association would soon be in a position to attack this problem. It seemed to be fairly well agreed that internship agencies should be inspected, and if they meet certain standards, approved for training, much as university psychology departments are now accredited for training in clinical psychology.

The inspection and approving of agencies or institutions used for clerkship training seems to be a problem of a different sort, since at that level the universities themselves take a major share of the responsibility for supervision. Nonetheless, it was felt that the entire

question of standards for field work agencies should receive attention in the near future. (See also Chapter 10.)

COORDINATION IN STUDENT SELECTION

The Conference recognized that present selection procedures often require an inordinate amount of time and expense for students applying to graduate schools for work in clinical psychology. If one student applies to several schools, he is often required to fill out a large variety of forms, take several duplicating tests, and generally furnish a large amount of personnel information. A central clearing house that could serve as a center for distributing such information to the universities and generally coordinate the application material would probably help to increase the usefulness of the material in selection procedures and eliminate much of the unnecessary duplication of effort.

From the universities' standpoint, such a clearing house would also help in obtaining personnel information more quickly and would reduce the reluctance felt by many psychology departments in requiring complete information about the applicant. The center might also help to establish a common date for the acceptance of applicants, thereby reducing much of the confusion that now occurs during the spring and summer before the beginning of the school year.

Many participants at the Conference were interested in establishing such a clearing house, but no workable plan was advanced to eliminate the difficulties entailed. It was hoped that the discussions that had taken place would serve to define the need so that other conferences might prepare plans to establish a central office, arrange for necessary financing, and solve the other problems connected with such a project. (See also Chapter 11.)

FINANCING OF GRADUATE TRAINING

The financing of graduate training in clinical psychology has considerable effect on the quality of students being trained in the

universities. At the present time, governmental programs, such as those sponsored by the Veterans Administration, the United States Public Health Service, the Army, and some of the individual states, are enabling psychology departments to select students with little or no regard for the financial status of the applicant. If these sources are eliminated, and no substitutes are provided, serious financial problems are likely to affect markedly both the number and quality of graduate students in clinical psychology. (See also Chapter 11.)

THE MEDICAL ORIENTATION OF CLINICAL PSYCHOLOGY

By tradition and in current practice, clinical psychology occupies a peculiar position in regard to the allied fields of psychiatry, education, social work, vocational guidance, and, most recently, public health nursing. In certain respects, clinical psychologists serve as research workers in each area mentioned, as well as making their own contributions to the clinical work carried on in the mental health area. During and after the second World War, the clinical psychologists found many opportunities for work in close relation to the medical profession. There have been attempts to define the clinical psychologist as one who is primarily competent to work with mentally disordered patients in a psychiatric hospital or psychiatric clinic. Other suggestions have been made to combine psychological training with a limited medical training in order to produce a new profession of "medical psychologist." A third group has argued that psychologists have certain competencies that are related to but often independent of medical practices. Resistance to each of these suggestions has arisen.

This issue has not been settled formally, since it is not the kind of question that can be answered by a resolution or vote. There are pressures upon clinical psychology to revise its graduate education to meet more completely the needs of patients in a psychiatric setting. These pressures come from both within and without the profession. Certain universities emphasize the psychiatric aspects of their training programs. Job opportunities also help to determine the

direction the field will take. Furthermore, two groups associated with the American Psychological Association, the Committee on Training in Clinical Psychology and the American Board of Examiners in Professional Psychology, can exercise a strong influence on the type of training to be given in accredited university departments.

If only indirectly, the Conference seemed to reflect a desire for clinical psychologists to continue to develop an independent profession that has close ties with medicine in general and psychiatry in particular, but which does not ally itself completely with any one of the related fields. There was general agreement that biological sciences should be included in both the undergraduate and graduate training of students. There was agreement that psychiatrists and social workers should, wherever possible, participate in graduate training. A very large majority voted in favor of a resolution that "a substantial portion of the internship year" should be spent in a psychiatric setting.

There were also strong opinions to the effect that clinical psychology has spheres of interest that are only remotely related to the medical profession. In the schools and colleges, in agencies dealing with the relatively normal, and in many areas of research, the need for medical collaboration or supervision is often secondary.

Thus the Conference appeared to take the position that graduate students in clinical psychology should expect to receive not only specific training in techniques and areas of knowledge directly related to the medical and psychiatric domain, but also training in other areas. Whether this position will be generally supported remains for the future and other conferences to decide. (See also Chapter 13.)

METHODS OF TRAINING IN ETHICAL PRACTICES

One entire chapter of this report is concerned with methods for training students in ethical clinical practices and for promoting such practices among professional psychologists. Training in ethics is

mentioned here only because of the need to devise more and better methods for insuring that such training will take place. The Conference was unanimously agreed that universities have the responsibility for this training. There seems to be little reason to fear that accredited clinical psychologists are lacking in ethical indoctrination. The major problem is in reality largely confined to the clearing up of misunderstandings between clinical psychology and the allied professions, and to the distinction between the well-trained clinical psychologist and the unqualified persons who by calling themselves clinical psychologists endanger the status of bona fide members of the profession. The lack of certification or licensing in most states makes it difficult if not impossible for members of other professional groups, as well as the public, to distinguish the qualified from the unqualified person.

As a new profession in the field of human welfare, clinical psychology will, to a large extent, be judged by its ability to meet the level of ethical practices in the related professions. As a developing profession, it must make sure that its methods and techniques are not exploited solely for personal gain. (See also Chapter 5.)

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APPENDIXES

APPENDIX A

*Recommended Graduate Training Program in Clinical Psychology**

REPORT OF THE COMMITTEE ON TRAINING IN CLINICAL PSYCHOLOGY OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION SUBMITTED AT THE DETROIT MEETING OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION SEPTEMBER 9–13, 1947 †

At the meeting of the Board of Directors of the American Psychological Association in Ann Arbor, March 28–30, 1947, the President was authorized to appoint a special Committee on Training in Clinical Psychology to perform the following tasks:

a. Formulate a recommended program for training in clinical psychology.

b. Formulate standards for institutions giving training in clinical psychology, including both universities and internship and other practicum facilities.

c. Study and visit institutions giving instruction in clinical psychology, and make a detailed report on each institution.

d. Maintain liaison with other bodies concerned with these problems, including the committees of the American Orthopsychiatric Association, the National Committee for Mental Hygiene, and others.

The undersigned persons constitute the Committee as finally appointed. The Committee, because of the relatively short period that it has had to work, has limited itself in this report to presenting a recommended program of training in clinical psychology.

The work of our Committee insofar as it relates to a training program grows naturally out of the activities of several previous committees and groups. The historical aspects of the development of clinical psycholo-

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gical training has been thoroughly covered by Morrow (*9*). Of particular relevance are the 1943 "Proposed Program of Professional Training in Clinical Psychology" of the Committee on Training in Clinical (Applied) Psychology (*1*) and the 1945 Sub-committee Report on "Graduate Internship Training in Psychology" (*4*). A recent issue of the Menninger Bulletin (July 1947) describing "The Menninger Foundation School of Clinical Psychology" and the July 1946 "Internship and Externship Programs" issue of the *Journal of Consulting Psychology* are also of considerable importance in this context. The report of the Committee on Graduate and Professional Training (*10*), although more directly related to future activities of our Committee, in some respects also bears on the present report.

The program here presented is especially timely because of the existing ferment in the field of psychology, particularly in the area of clinical psychology. The Harvard University Commission's report (*6*) suggests some of the possibilities which lie ahead of psychology in the near and distant future. With respect to clinical psychology, one sees on the one hand the breathless preocupation with actual training which has resulted largely from the Veterans Administration and United States Public Health Service programs, and on the other hand the deep concern with the goals and trends of this training both within the Psychological Association and on the part of organizations interested in the fields with which clinical psychology is associated. The Josiah Macy Jr. Foundation has held the first of a series of Conferences on Clinical Psychology (*8*); the American Psychiatric Association and the Group for the Advancement of Psychiatry have Committees on Clinical Psychology and the American Orthopsychiatric Association and the National Committee for Mental Hygiene are engaged in activities which in one respect or another involve the evaluation of the functions of clinical psychologists. It is, therefore, especially desirable that the Association set forth its own official policy in this important matter of training and that it play the major role in determining the content and goals of such a program.

We are cognizant of the great difficulties which the shift from an academic to a professional program involves in a university setting. We recognize that this change must take much effort and time and that even were it possible to set up a fairly fixed schedule of training, such a step would at present be both premature and ill-advised because of the great need for experimentation in ways of implementing a sound program. We are therefore emphasizing the goals and principles of what we consider a desirable program rather than attempting to lay out a detailed blueprint. We have decided to limit our present con-

sideration of training to a program at the four-year doctoral level because of our firm conviction that professionally qualified persons cannot be given adequate background training in less time. This is in line with a decision independently arrived at by the Policy and Planning Board (2) that further training of clinical psychologists at the MA level be discontinued. It should be emphasized however, that this decision does not preclude the training of persons to apply psychological principles in specialized areas such as remedial teaching, vocational and educational counseling, educational testing, etc. However, such persons are in our opinion not clinical psychologists and the present report is not concerned with their training. We have further decided not to let our program be determined in any way by present practices in training which arise from special situations such as those created by the financial arrangements of the Veterans Administration. We have, rather, tried to present what we consider ideally desirable in the present state of our knowledge, and we have left to the university the practical working out of the program according to local conditions.

PRE-PROFESSIONAL REQUIREMENTS

In that wise volume, "Medical Education," (5, p. 176), Abraham Flexner says ". . . the medical school cannot expect to produce fully trained doctors; it can at most hope to equip students with a limited amount of knowledge, to train them in the method and spirit of scientific medicine and to launch them with a momentum that will make them active learners—observers, readers, thinkers, and experimenters—for years to come. . . . The general arrangement of the curriculum, if sound, can make this task a bit easier, or if unsound, a bit harder; but in general much more—very much more—depends on teacher and student than on curricular mechanics or teaching devices."

If we substitute clinical psychology for medicine, this statement expresses the essential point which we wish to make in this report. Our task is to find good teachers to give good students good training that will start them off in the first stages of their careers as clinical psychologists. This report will be concerned in some detail with ways of meeting the problems that arise in attempting to achieve this task.

What specific goals do we have in mind in the preparation of the clinical psychologist? Clinical psychology seeks to acquire systematic knowledge of human personality and to develop principles and methods by which it may use this knowledge to increase the mental well-being of the individual. If we recognize that clinical psychology is both a science and an art calling for scientific rigor tempered by personal and social sensitivity, we can specify these goals fairly clearly.

The more carefully the present scene is examined and the more thoughtfully the future is viewed, the more convinced are we of the need for preparing the clinical psychologist with a combination of applied and theoretical knowledge in three major areas: *diagnosis, therapy* and *research.* The purpose is not to develop persons with encyclopedic proficiencies nor is it directed at disproving the contention of some that the scientific and therapeutic attitudes mix poorly in the same person (a view which we are unwilling to accept until definite proof is forthcoming). Rather is it our purpose to see that the necessary broad training is provided that will make later specialization on a sound foundation possible. It becomes increasingly clear that persons having a specialized background in only part of one of these fields, for instance, Rorschach testing, or counseling, or electroencephalographic research, cannot function adequately. We go even beyond this and say that broad training, if it is in only one of the three major areas, is quite inadequate for ordinary clinical psychological work, to say nothing of teaching and preventative endeavors, two major fields of activity which require special attention.

The ability to carry out effectively the combination of functions called for depends upon the clinical psychologist's being the right kind of person, a person who has a relevant informal experience background into which has been integrated the proper formal education, both undergraduate and graduate.

What characteristics does the "right kind" of person possess? As yet, we do not know definitely, for research on this important problem has only begun. It is generally agreed, however, that especially important are the personality qualifications represented by a reasonably well-adjusted and attractive personality. Until dependable research data are available, the following list, which includes the kind of specific qualities experienced observers believe clinical work calls for, may be useful:

1. Superior intellectual ability and judgment.
2. Originality, resourcefulness, and versatility.
3. "Fresh and insatiable" curiosity; "self-learner."
4. Interest in persons as individuals rather than as material for manipulation—a regard for the integrity of other persons.
5. Insight into own personality characteristics; sense of humor.
6. Sensitivity to the complexities of motivation.
7. Tolerance; "unarrogance."
8. Ability to adopt a "therapeutic" attitude; ability to establish warm and effective relationships with others.
9. Industry; methodical work habits; ability to tolerate pressure.
10. Acceptance of responsibility.

11. Tact and cooperativeness.
12. Integrity, self-control, and stability.
13. Discriminating sense of ethical values.
14. Breadth of cultural background—"educated man."
15. Deep interest in psychology, especially in its clinical aspects.

The list is formidable but in the present state of our knowledge, represents the kind of selection goals towards which we must work. Characteristics of this type seem a necessary foundation for work in a field which requires so much in the way of maturity, sensitivity, and knowledge.

How are we to obtain such persons for training? Problems of both recruitment and selection are involved. The problems of recruitment are more difficult than they are in such major professional fields as medicine and law, since the latter are well-established and known to youngsters from quite early years. For the present, the major effort in recruiting will have to be made at the college level through teachers of psychology and vocational advisors who are on the lookout for promising candidates. In coming years, growing general acquaintance with the field and the multiplication of earlier courses in psychology at the secondary level are likely to lead the student to think of clinical psychology as a lifework. The first rough selection could then come in the secondary schools.

Beyond the problem of recruiting a sufficiently large number of persons to maintain the necessary supply of clinical psychologists lies the major task of proper selection at the point of entrance into graduate work. Here, besides the ordinary selective devices such as are provided by the credentials of the candidate, the Graduate Record Examination and the devices which are being developed in the "Research Project on the Selection of Clinical Psychologists under contract with the Veterans Administration" under the auspices of the University of Michigan (*7*) should be of help in selecting the best candidates. It is not necessary to elaborate on the obvious point that besides rigorous selection at the point of entrance into graduate work a process of selection must go on throughout the program.

Given the proper kind of person, what may we expect of him in the way of informal background experience which may be considered relevant? For the present we shall devote our attention to the nonacademic experiential background of the person. Since it seems reasonable to expect the clinical psychologist to be interested in people and have a broad base of human contacts, he should have had experiences, particularly in his college years (summer holidays and other spare time), involving close relations with both ordinary and unusual persons

in field, factory, institution, or laboratory. In addition to direct contact with people of various kinds he should have had the indirect acquaintance with people that comes from immersion in great literature, because of the emphasis which such portrayals place on the molar aspects of behavior and the insights into human nature that they give. Anything that reading may accomplish to broaden his acquaintance with the wide range of psychological expression, whether in relation to individuals or cultures, is so much relevant background for him.

What can we say about the formal educational background which we may expect from the candidate who is entering the graduate program? Two distinct points of view are generally expressed. On the one hand, there is some demand that students come with a common, fairly defined background, especially in psychology, in order to make graduate instruction easier. On the other hand, some hold that, for the broad development of the field, to cast all the participants in the same mold would be undesirable. Medicine, the proponents of this view indicate, has experimented with a rather rigid prerequisite program but is raising more and more question about its desirability. The solution probably lies somewhere between the two points of view. It seems to us that certain general requirements for the undergraduate program which the student could ordinarily be expected to meet can be laid down. In exceptional cases, provision to waive these should, of course, be made.

The undergraduate program must be recognized as at most *pre*-professional. The professional and the more advanced courses in psychology should in general not be open to the undergraduate. The undergraduate program should be directed at providing a broad cultural and scientific base for specialized graduate study. The courses should help the student to attain a first insight into the structure and dynamics of human behavior, an understanding of the biological and social development of the individual, and a preliminary acquaintance with the principles and methods of collecting and evaluating data.

More specifically, as an example of what a basic undergraduate program might include, the following is presented:

1. *Psychology.* An approximate optimum of twenty semester hours, to consist essentially of courses for undergraduates. The student must be permitted to take a sufficient number of psychology courses to enable him to acquire a fair acquaintance with the content of the field of psychology, both in its general and in its laboratory aspects, but he should not be permitted to concentrate heavily in it. The main emphasis should be on courses in dynamic psychology [1] which consider

[1] We shall have occasion to refer repeatedly to "dynamic psychology," a

crucial human problems at a fairly rigorous scientific level. Mass "titillating" courses directed at the general student body are definitely not what we have in mind here.

2. *Biological and physical sciences.* Approximately twenty semester hours of which the major part should preferably be in biology including genetics, and the balance in physics and chemistry. Satisfactory secondary school preparation in the latter two would reduce the amount required at the college level.

3. *Mathematics and statistics.* Approximately nine semester hours in mathematics and statistics, with special emphasis on their logical principles.

4. *Education.* Approximately six semester hours in the fundamentals of educational philosophy, and experimental didactics in the form of practice teaching, if this can be arranged.

5. *Social sciences.* Approximately twelve semester hours in sociology, anthropology, and economics. (Political science or history might be substituted for the last.)

6. *History of Culture.* Approximately nine semester hours in history of civilization, comparative literature, comparative religion, philosophy, etc.

7. *Psychology as revealed in literature.* Approximately six semester hours in "literary psychology" if this can be arranged.

8. *Languages.* Reading knowledge of French and German. (Some consideration should, however, be given to the desirability of substituting other languages, for example, Spanish and Russian.)

We wish to emphasize that the undergraduate program cannot be appraised according to credit hours or in relation to specific courses. Each candidate's record must be examined on its merits to see how far it meets the spirit of the background requirements of breadth, good introductory acquaintance with psychology, and fair acquaintance with the biological and social sciences. If a choice is to be made between the latter two groups, there seems some reason for postponing further study of the social sciences to the graduate period. The student, being more

term which has to some extent taken on the "blessedness" of James' old lady's "Mesopotamia." Because of this, the term is not in good repute with some persons. However, we find no term so satisfactory for describing what we have in mind—the "how" and "why" of human behavior as opposed to the static, structural "what." Without getting involved in what would in the present context be merely irrelevant semantics, the definition given in Warren: "A systematic interpretation of mental phenomena, regarded as a succession of causes and effects with emphasis upon internal drives and motives," or the definition provided by one of us: "Fundamental theories of motivation, conflict, and resolution of conflict, applied to an understanding of normal and abnormal behavior" essentially describes what we refer to as "dynamic psychology."

mature at this time, is better able to grapple with its relatively greater uncertainties.

GRADUATE PROFESSIONAL PROGRAM

General Principles. The general principles which underlie the graduate program appear to us of primary importance—in fact much more important than the details of the program. If clarity in the formulation of goals exists, there should be relatively little difficulty about agreeing on the means for implementing them. As has already been indicated, it is the opinion of the Committee that the setting up of a detailed program is undesirable. Such a step, if accepted generally, would go far in settling clinical psychology at a time when it should have great lability. Considerable experimentation with respect to the personality and background of students as well as the content and methods of courses will for a long time be essential if we are to develop the most adequate program. Our aims are rather to achieve general agreement on the goals of training and encourage experimentation on methods of achieving these goals and to suggest ways of establishing high standards in a setting of flexibility and reasonable freedom. We also hold that the goals should not be determined by special situations and special demands, but should be oriented toward the question of what is the best training for the clinical psychologist.

Against this general background the principles which we consider important are the following:

1. A clinical psychologist must first and foremost be a *psychologist* (2) in the sense that he can be expected to have a point of view and a core of knowledge and training which is common to all psychologists. This would involve an acquaintance with the primary body of psychological theory, research, and methods on which further training and interdisciplinary relationships can be built.

2. The program of education for the doctorate in clinical psychology should be as rigorous and extensive as that for the traditional doctorate. In general this would represent at least a four-year program which combines academic and clinical training throughout but which includes intensive clinical experience in the form of an internship.

3. Preparation should be broad; it should be directed to research and professional goals, not to technical goals. Participants should receive training in three functions: diagnosis, research and therapy, with the special contributions of the psychologist as a research worker emphasized throughout. Although many will probably tend to specialize in one or another of these areas after obtaining the degree, the Committee feels strongly that there should be training in each of these areas

during the graduate period. We are particularly concerned that training shall be of such a quality as to eliminate the possibility that a technician, whether in the sense of a directive or nondirective counselor, a Multiphasic specialist, a Binet tester, a Rorschach specialist, or a remedial instructor, will be turned out as a clinical psychologist, and so depended upon for a range of work he will be unable to do.

4. In order to meet the above requirements the program calls for study in six major areas: a. General psychology; b. Psychodynamics of behavior; c. Diagnostic methods; d. Research methods; e. Related disciplines; f. Therapy. Such a program should go far towards reducing the dangers inherent in placing powerful instruments in the hands of persons who are essentially technicians, persons who from the standpoint of the academic group have no real foundation in a discipline, and who from the standpoint of the clinical group have no well-rounded appreciation of the setting in which they function.

5. The program should concern itself mainly with basic courses and principles rather than multiply courses in technique. It is simple to organize a program that includes innumerable courses of the latter type and come out in the end with a poorly trained person. The stress should be laid on fewer, well-integrated courses which subtly but inevitably leave the student with a sound background, on which he can build knowledge of techniques as he needs them. The courses should be so arranged that more advanced courses really call for knowledge acquired in preceding courses and are built on these. This has too infrequently been true in psychology graduate programs with the result that students have not had the clear notion of progress towards a goal that law students and medical students have. The relationship of the course material to personality theory should be constantly emphasized and unless the whole program is oriented in this direction we doubt its final effectivenes for achieving the stated goals.

6. Courses should be scrutinized for their content, rather than judged by their titles. Equally important is the way the content is handled, that is, the quality of the teaching. Other factors to be evaluated are the internal integration of the course and its integration with other courses, both academic and field. Departments of psychology have perhaps been too much concerned with providing their instructors with freedom to organize their courses as they saw fit under an assigned title. This has frequently resulted in considerable duplication in courses and in the omission of important areas. In either case the student suffered. Without in any way infringing on the instructor's fundamental freedom, it would seem possible, through department and individual conferences, for instructors to lay out courses which

are complementary and supplementary to the others given, rather than overlapping because they are ignorant of the general content of colleagues' courses. Courses should as much as possible involve active student participation in preference to merely requiring listening or even watching demonstrations. Individualization of instruction, detailed personal supervision, and the encouragement of initiative and self-reliance must be recognized as important aspects of the teaching. The student should come in contact with a number of instructors representing a variety of points of view and types of experience.

7. The specific program of instruction should be organized around a careful integration of theory and practice, of academic and field work, by persons representing both aspects. Just as there is great danger, in the natural revolt against "academic" dominance, of ending up with a "practical" program, so is there danger in the continued dominance of the academy. It is important to break down the barriers between the two types of approach and through their smooth integration impress the student with the fact that he is taking *one* course of training provided by *one* faculty.

8. Through all four years of graduate work the student should have contact, both direct and indirect, with clinical material. This can be accomplished in the theoretical courses through the constant use of illustrative case material with which the instructor has had personal contact. The student should from the first year be provided with opportunities for actual contact with human material in naturalistic, test, and experimental situations in the setting of practicum, clerkship, and internship. Throughout, the effort should be made to maintain and to build upon that most valuable quality, the naive enthusiastic interest in human beings, with which the student first comes into the training program.

9. We have just made the point that the student should have contact with clinical material throughout the four years of training. Equally important is the need for contact with normal material. Opportunities should be provided to enable the student to become acquainted with the range of normal and borderline persons who never establish clinical contacts. Such training is essential in order to keep the student balanced in his interpretation and understanding of the abnormal.

10. The general atmosphere of the course of training should be such as to encourage the increase of maturity, the continued growth of the desirable personality characteristics earlier considered. The environment should be "exciting" to the degree that the assumed "insatiable" interest in psychological problems is kept alive, the cooperative attitude

strengthened, and the passivity usually associated with so much of traditional teaching kept at a minimum. The faculty must recognize its obligation to implant in students the attitude that graduate work is only the beginning of professional education.

11. A distinct weakness in the training of psychologists, when compared with that of physicians and social workers, is the lack of sufficient feeling of responsibility for patients and clients.[2] The program should do everything possible to bring out the responsibilities associated with the activities of the psychologist. There should be persistent effort to have the student appreciate that his findings make a real difference to a particular person and to that person's immediate group.

12. A systematic plan should be laid to use representatives of related disciplines for teaching the trainee in clinical psychology, and opportunities for joint study with students in these disciplines should be provided. Through these approaches the student learns to work closely and in cooperative fashion with those whose methods may be different but whose goals are quite similar. In these settings he learns to acquire modesty about his own contribution, and to value the "team" approach to the problems of both a service and research nature that he meets, problems which, because of their difficulty and complexity, require a concentrated group attack. In the service aspect he must learn that the team approach calls for the coordinated thinking of various specialists on the problems of a particular patient and that participation in such group activity involves not only immediate, but continuing, responsibility for the client, whether direct or delegated, on the part of all of the members of the team.

13. Throughout the course of training there should be an emphasis on the research implications of the phenomena with which he is faced, so much so that the student is finally left with the set constantly to ask "how" and "why" and "what is the evidence" about the problems with which he is faced. There is probably no more important single

[2] The words "patient" and "client," although not quite satisfactory terms for the person with whom the psychologist establishes "interpersonal relationships," are used throughout this report, either together or singly, but always interchangeably. Because of the variety of situations in which the clinical psychologist is called upon to work—medical and non-medical, normal and abnormal—neither term accurately designates all the persons with whom he deals. The old psychological term "subject" is sufficiently broad, but unsatisfactory because of its implications of exaggerated dominance and direction; the other old term "observer" is even more unsatisfactory because of the implication of emotional distance and marked nondependence which it carries. For the present, to avoid awkwardness in expression, we must be satisfied with "patient" or "client," with the understanding that either term carries the broader meaning here indicated.

task placed on the teaching staff than this direction towards research.

14. In addition to the research implications of the data he should become sensitive to their social implications; he must acquire the ability to see beyond the responsibilities he owes to the individual patient to those which he owes to society. Medicine has developed a code which is admirable so far as concerns responsibility to the individual patient, but has paid relatively less attention to the other type of responsibility. It is our hope that psychologists will gradually acquire more of the medical attitude towards individual patients but develop a high degree of social responsibility as well.

PROGRAM OF GRADUATE TRAINING

As has already been indicated, the program of graduate training falls naturally into six major instructional areas: general psychology, dynamics of human behavior, related disciplines, diagnostic methods, therapy, and research methods. For purposes of exposition of the general plan it seems best to consider the program according to these categories rather than by school year. Under each heading will be discussed the progressively advancing courses falling roughly into the particular category. The classification is, of course, arbitrary and there is a considerable amount of overlapping in both the theoretical and practical aspects. The description of an experiment in perception, for instance, can be significant not only because it points up fundamental perceptual theory, but it can also do the same for psychodynamic theory, research methodology, and physiological relations and—it is not inconceivable—for therapy.

Although it is not our intention to encourage filling up the student's time with courses to so great an extent as is the present practice, for instance, in the medical program, it is still our belief that graduate students in this program can carry heavier schedules than are ordinarily called for by graduate schools. The students must be given time to read and think but we believe these goals need not be sacrificed—in fact they might even be strengthened—if the program were thought of as requiring more semester hours of teaching contact through the year in order to get in *necessary* course work.

A. *General Psychology.* In view of the fundamental tenet accepted by the Committee, namely, that clinical psychologists are primarily psychologists, it is clear that due attention must be paid to preparation in the general aspects of psychology. It is our hope, however, that in the presentation of the general courses now under consideration instructors will keep in mind the need for including material related to personality theory and that they will consider the implications of

the phenomena they are discussing in the context of total behavior. It is our hope, too, that the trend of the past towards emphasizing the segmental aspects exclusively will be considerably reduced. The courses [3] in this category which should generally be included are:

1. General, physiological, and comparative psychology.
2. History of psychology and contemporary schools of thought.
3. Developmental psychology—Fundamental theories of genetic development: child, adolescent and adult; individual differences.
4. Social psychology.

B. *Psychodynamics of Behavior.* If we are to develop the kind of clinical psychologist this program aims for, considerably more emphasis than in the past will have to be placed on permeating the program with theory of personality and psychodynamics. There is no other aspect of the program that is more important and that has so many ramifications. If a dynamic orientation is what we are after, then there can be no half-measures. To accomplish such a purpose it is necessary that as many of the instructors as possible be well acquainted with psychodynamic theory and that they present their material in the light of such theory both in the classroom and in the field. The suggested courses in this area are:

1. Dynamic psychology—Fundamental theories of personality and motivation of normal and abnormal behavior.

2. Experimental dynamic psychology—Conferences and laboratory work. Starting with a selected group of classical experiments in general psychology that bring out fundamental experimental principles, the course might go on to the consideration of the theory and design of clinical research and experiments on personality characteristics and dynamics. It should also involve the critical analysis of published studies and the application of experimental techniques to actual problems in the clinical field. Some university might perhaps be interested in the experiment of conducting this course concurrently with the previous course—conceivably even as a single unit.

3. Psychopathology—The consideration of symptoms and symptom complexes in various mental disorders with emphasis on nosology to some extent but more particularly on the mechanisms and dynamics behind symptoms. The course should be organized largely around actual case presentations.

[3] At this point and elsewhere when specific courses are considered we have deliberately refrained from indicating the semester hours to be devoted to them. We conceive of some of these as being three-hour courses and others as much as 12-hour courses. The decision as to their length had best be left to the individual university.

C. *Diagnostic Methods.* Diagnostic study has taken on an increasingly important role in the functioning of the clinical psychologist. This statement may seem somewhat anomalous considering the fact that for a long time "testing" was widely considered the only function of the clinical psychologist. The difference lies in the fact that whereas the functions of the clinical psychologist have been broadened considerably there has been an equal broadening of the concept of what testing involves and a great expansion of the variety of procedures available to him. Besides standard tests there are work samples, psychodrama, real life segments, and situational tests among the methods now at his command. At one time diagnosis implied merely a type of "pigeonholing." At present this represents only a minor aspect of what is called for. Now diagnosis concerns itself with the origin, nature, and especially the dynamics of the conditions under investigation, and with suggesting hypotheses as to outcome under varying forms of disposition. Its important contribution to personality research, to psychiatric diagnosis, and to therapy are being recognized increasingly. The need for detailed and intensive training in this area is obvious. How shall this training be carried out?

There is a certain logical order in the steps of training which seem to us to be essentially these: Principles and theory, demonstrations, preliminary laboratory experience (in the sense of practice by students on each other and on any other available subjects), practicums in the form of clerkships (organized short periods of part-time training at established field centers) and internships (organized, full-time, extended periods of training at established field centers).

The devices with which the student should become acquainted and in which he should attain proficiency are many and of varying degrees of difficulty. Increasing experience with students in this field convinces us, however, that before actually beginning to work on diagnostic devices the student should have a preliminary and fairly extensive period of training devoted to naturalistic observation and description, procedures on which these devices are fundamentally based. Because so much of clinical psychology (and psychiatry) depends on the description of the complexities of behavior, we would recommend that a considerable portion of the time to be set aside for diagnostic devices in the first year be spent rather in training students in careful observation and report. For this purpose one-way screens, paired observers, and recording devices of both sound and visual types, should be used in settings where individuals and groups are under observation in free and controlled situations. Constant checking of observer's reports against each other, against supervisor's observations, and against the

mechanical devices should be standard practice. It is important that a healthy respect for careful observation and report be developed in students who are going to work in a field where a good share of the time the major instrument, in both respects, is the observer himself. With regard to reporting, both in this connection and in connection with diagnostic study, strictness and insistence on high standards of succinctness and accurate terminology are essential. A further argument for early training in observation is suggested by a reading of Flexner (5, p. 253), who, quoting Wenkebach's statement, "Das Wissen verdrängt das Sehen," points out the dangers which come from the early acquisition of technical terms and how frequently such knowledge serves as a barrier to accurate observation of the conditions with which the student is concerned.

Concurrent with the observational field work of the first year might come a broad survey course in clinical psychology whose purpose it would be to provide the student with a perspective of the whole field of clinical psychology. This would include a consideration of the varieties of duties and responsibilities which may be involved in different settings in relation to clients, other professions, and the public. Such a course might be followed by instruction in the technique of taking histories and interviewing, at least in part given under the guidance of experienced social workers and psychiatrists. The preparation of an autobiography during this period is also to be recommended.

After this preliminary background, which has emphasized molar techniques and has provided acquaintance with some clinical material, there follows naturally a systematic course in the theory and practice of diagnostics. Such a course should begin with a consideration of the theory and philosophy of diagnostics; it should provide an understanding of the place of diagnostic procedures in systematic psychology, its relationship to other forms of directed acquisition of knowledge such as naturalistic observation and experiment, its history in detail, and its strengths and weaknesses as a scientific method and as an applied technique. A presentation of the theory and practice of test construction might follow.

The student should then acquire an extensive, if superficial, acquaintance with the wide variety of test and other diagnostic devices: sensory and motor; intelligence: verbal and performance, individual and group; educational and vocational guidance; personality: objective, projective, and situational; and some general notions about their applicability, roughly in the stated order. He should, of course, have a more intensive acquaintance with the selected devices generally used in clinical settings. Whereas he may acquire knowledge of the former

from general test survey courses, his knowledge of the latter should be acquired from specialized courses devoted to these techniques. In this connection, the faculty must resist pressure from the students who will put up considerable clamor to be permitted to do projective testing (just as some press for therapy) before they have the necessary relevant clinical and theoretical background for the proper use of these complex techniques. Knowledge about tests should not be derived from didactic teaching alone nor from occasional practice on fellow-students tacked on to the course. Practicums and clerkships, as has repeatedly been emphasized, must be recognized as essential and integral parts of the university training, and periods of practice with subjects in clinical settings must be provided. The general emphasis during the university period should, however, not be on too intensive practice in any one device nor with any one type of subject; rather, it should be directed toward getting across to the student the "feel" of contact with a variety of types of patients as well as the "feel" of a variety of types of test procedures. With this in mind the university should have available many neighboring clinical centers for clerkships, such as schools, child guidance units, schools for the feeble-minded, psychopathic and other psychiatric hospitals, mental hygiene clinics, general medical and surgical hospitals, educational and sensory-motor disability clinics, prisons, industrial units and vocational guidance centers. Each student should rotate among at least four of these.

During the internship or externship it is inevitable, and in fact desirable, that a certain amount of the activity of the previous years is duplicated. The student should at the time he commences the internship have, besides a general background in basic general and dynamic psychology, a broad acquaintance with test techniques and an elementary appreciation of their application. He has now come to a setting whose major contribution is to throw him into direct, constant, and intensive contact with human material—a setting in which he can apply both his theoretical knowledge and his beginning skills.

In this environment, where the emphasis is on the individual patient, rather than the problem or the technique, there are certain goals related to test procedures which one expects the student will reach. It is expected that besides acquiring skill, through repeated practice, in the administration and understanding of a wide variety of tests, he will learn when tests are called for and when they are not, what tests and combinations of tests are required in specific problems, and that he will learn their weaknesses as well as their strengths. Besides acquiring a sensitivity to the diagnostic and prognostic aspects

of his test findings one hopes that he will become sensitive to their therapeutic implications as well. In fact, there should be an effort to develop in him a "therapeutic attitude" towards his diagnostic work; an attitude that involves learning to avoid probing and carrying out misplaced therapy; an attitude that involves leaving the patient the better rather than the worse for the experience—this without violating the controls or the spirit of good diagnostic procedure. It is expected that he will acquire some sense of balance between the extremes of rigorous pedantic exactness and sloppy guessing, that he will recognize that different problems lend themselves to differing degree of control, and that there are times and stages of development when a rough negative correlation appears to obtain between psychological meaningfulness and degree of control. It is to be hoped that he will learn that what is important, while working always for reasonably greater control in the clinical setting, is to be honest about the degree of control obtained at the particular time, to admit that one is ignorant or merely hypothesizing when such is the case. His supervisors should strive to have him attain enough security about presenting tentative conclusions so that he does not escape into meaningless profundities or into exactness about the insignificant when he is overcome by the complexities and the difficulties of the significant.

These courses are suggested for the diagnostic series:

1. Observational techniques and reporting.
2. Survey of clinical psychology.
3. Methods of case study, case analysis and interviewing.
4. Theory and practice of psychological diagnostics:
   a. Theory of testing and test construction
   b. Verbal "intelligence" tests
   c. Non-verbal ability tests
   d. Tests of sensory and perceptual function
   e. Tests of motor function and motor skill
   f. Educational achievement tests
   g. Vocational tests
   h. Clinical tests of psychological deficit, aphasia, conceptualization, etc.
   i. Projective and other personality procedures
   j. Clinical analysis and integration of diagnostic devices.

D. *Therapy.* It is our thesis that no clinical psychologist can be considered adequately trained unless he has had sound training in psychotherapy.[4] The social need for the increase of available therapists is

[4] Psychotherapy is a process involving interpersonal relationships between a

great. Clinical psychologists are being called upon to help meet this need, as well as the greater research need, and we anticipate that many will devote a part of their time to some form of psychotherapy. Our strong conviction about the need for therapeutic experience grows out of the recognition that therapeutic contact with patients provides an experience which cannot be duplicated by any other type of relationship for the intensity and the detail with which it reveals motivational complexities. A person who is called upon to do diagnostic or general research work in the field of clinical psychology is seriously handicapped without such a background; a person who is called upon to do research in therapy (a field to which psychologists of the future must, for various reasons, devote themselves prominently) cannot work at all without such a background.

Many important problems of an inter-disciplinary, social, and legal nature are raised by such a program, questions which are not pertinent to the discussion here. There is no reason, however, why these cannot be taken care of eventually by the various Committees and Conferences concerned with the problem. We feel that members of other groups, such as psychiatrists, psychoanalysts, and social workers, who have been concerned predominantly with problems of therapy should be called upon, to as great an extent as possible, to take an important role in the teaching of the clinical psychologist. A by-product of this association could not help but be a reduction of some of the difficulties raised by the mentioned problems.

Because of the greater complexity and inexactness of the therapeutic process it would seem reasonable that study in this area begin not before the second year. The work might be introduced by lecture and discussion courses on theory and methods, followed by practicums on simpler therapeutic techniques and on problems such as those which are involved in remedial work and guidance. Therapeutic activity of a more advanced (though still simple) kind should perhaps be left for the internship and fourth years of the program. During the internship, the student should be in an institution where detailed and close supervision is available. In the fourth year he has gained sufficiently in background, maturity, and appreciation of his responsibilities to the client, and to his own and other professions. Really advanced training in therapy is, with few exceptions, a problem of the post-doctoral period which requires considerable thought devoted to it.

The courses which should be included are:

1. Therapeutic theory and methods—Lectures and discussion.

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therapist and one or more patients or clients by which the former employs psychological methods based on systematic knowledge of the human personality in attempting to improve the mental health of the latter.

Introductory course in therapy and counseling; methods and techniques; evaluation of results. There should be considerable emphasis on different points of view in therapy and on common factors in the various forms of therapy.

2. Remedial aspects of special disabilities—Lectures and systematic supervised practice.

3. Techniques of guidance and counseling—Lectures and systematic practice under supervision in individual personality guidance and counseling of minor problems.

4. Personality therapy—Detailed consideration of case material in seminars; carefully supervised practice.

5. Techniques of group therapy—Lectures, systematic participation, and supervised practice.

E. *Research Methods.* Because of the academic background of psychology, a natural development has been that of all the disciplines in the mental hygiene field it is psychology which has been most concerned with research. It is important that this interest in research on the part of psychology continue, for as one surveys the scene the likelihood that the major burden of research will fall on the psychologist becomes clearer. If he permits himself to be drawn off into private therapeutic practice as has the psychiatrist, or into institutional therapeutic work as has the social worker, the outlook for research is dim in a field where the need is enormous. As has already been indicated, if a social need for therapy exists, then the need for research is even greater. The fact that there is not equal pressure for the latter is mainly due to the excusable but still short-sighted outlook of the public. The universities, with their more far-sighted orientation, have a serious responsibility to develop research interests and abilities in the clinical psychologists they train. The interest should be in research on the laws of human behavior primarily and on technical devices and therapy secondarily. Throughout the course of training, research attitudes and problems should permeate all aspects of the program, in the diagnostic courses and in therapy, as well as in the courses in general psychology and psychodynamics. The emphasis on personality theory, already mentioned, is closely related and should serve as further support to this point of view. Only from a concentrated attempt to build up such an attitude can we expect to draw from our training programs a substantial number of psychologists who will be interested in devoting themselves primarily to research, and a further number who will devote at least part of their time to such activity.

The courses in this area should include:

1. Experimental psychology—Conference and laboratory course of

a basic kind in experimental techniques, devoted mainly to the consideration of the more meaningful problems in general psychology, e.g., learning, reaction mechanisms, work activity, etc. Consideration should be given to variability of response—to the significance of the extremes of the distribution as well as to the modal and typical response—and to the clinical implications of these general problems.

2. Advanced statistics and quantitative methods in psychology and psychopathology.

3. Research in dynamic psychology—Conference and laboratory course which considers the theory and design of experiments in personality characteristics and dynamics; application of experimental and other research methods to the problems in the clinical field.

4. Dissertation—Preliminary work on the dissertation including the setting of the problem, preparatory reading, and the outlining of the project in detail during the second year. Actual experimental work on the dissertation carried out during the third (internship) year under joint supervision of university and field center. Final work on the dissertation during the fourth year.

F. *Related Disciplines.* Because of the problems with which he is constantly faced there is no psychologist who needs a broader background than the clinical psychologist. He works in a setting with medical specialists of many kinds: psychiatrists, physiologists, neurologists, to mention the most prominent, and with representatives of other disciplines such as social workers and educators with all of whom he has the closest contacts. On the one hand, his work may have specific physiological implications, on the other, broad educational and social aspects. He cannot be narrow; he must be able to meet his colleagues on common ground and at the same time see what the remoter implications of his findings are. That an adequate training program could be organized which does not include in it some of the background which such an assignment calls for is inconceivable. It has already been suggested that some of this background should have been acquired during the undergraduate period. But the greater part must necessarily come during the graduate period. Here, too, representatives from other disciplines should be used as much as possible in the training; in fact, it cannot be carried out without them.

The program should include:

1. Physiological sciences—Lectures and demonstrations. Selected aspects of physiology and anatomy: especially neurophysiology, neuroanatomy, autonomic nervous system, endocrinology, etc.

2. Introduction to clinical medicine—Lectures. Introductory course in clinical medicine to acquaint the psychologist with the major char-

acteristics of the clinical pictures of various diseases and with technical medical procedures which he will hear about in the settings where he works. Special attention should be given to those diseases which today are usually referred to as psychosomatic.

3. Social organization and social pathology. Lectures and field visits. A course to acquaint the psychologist with social structure, the pathological aspects of this structure as seen in crime, poverty, etc., and the agencies set up to take care of these. The major part of this course could most effectively be given by psychiatrically oriented social workers rather than sociologists.

4. Influence of culture on personality—Lectures on cultural anthropology's contribution to the understanding of personality.

We might summarize what has been presented in the preceding section, which covered the content of the program according to areas, by a brief statement of the content according to year levels.

The primary purpose of the first year of study is to lay the systematic foundation of knowledge of psychology, to achieve some degree of acquaintance with the physiological and other sciences needed for professional clinical work, and to train the student in good observational technique.

The program of the second year of graduate work is directed mainly at providing the student with the necessary background in the experimental, diagnostic, and therapeutic approaches to the problems of clinical psychology. Although a certain amount of teaching may still be carried on in the form of lectures, the major emphasis is on direct contact with patients, clients, or other subjects, either in the diagnostic or in the experimental setting. Practicum courses and clerkships in different clinical settings are essential elements of this year's program.

The third year consists of an internship whose content is discussed in fuller detail in a later section. The Committee believes that the third year spent in an internship and the fourth in a final year at the university is the most desirable arrangement, although other patterns should be experimented with. The advantages of this proposal are many: (1) The student is enabled to complete the analytic and final work on his dissertation at the university. (2) It permits the final integration of the experiences acquired during the internship with the more theoretical principles emphasized by the university, and emphasizes the unity of the course of training. Otherwise the internship may be considered as a mere appendage. (3) The return of graduate students with internship background to the university should have some influence in integrating the kind of training provided by the university and the internship center. It might also serve as a recip-

rocating educational influence upon the nonclinical university group, both students and instructors. (4) The student is placed geographically close to the agency which already has an established placement service and is therefore in a better position to aid him in the consideration of employment opportunities.

The program of the fourth year should be relatively elastic and could include most of the following:

1. Final work on dissertation.
2. Cross-discipline seminars (attended by representatives of psychology, anthropology, sociology, social work, psychiatry, etc.) that devote themselves to the discussion of psychology's relation to the other sciences concerned with the adjustment problems of the individual and the group. The purpose of these seminars should be to integrate the major principles of previous study and to point out the broader implications of the course of instruction for the personal and social scenes.
3. Seminar on professional problems—standards, ethics, etc.
4. Additional courses in psychology as needed to round out the individual student's program.
5. Additional courses in related fields as needed to round out the individual student's program.
6. Advanced therapeutic work, if indicated.
7. A program of self-evaluation, if indicated. (See later discussion of the problem of personal analysis.)

SPECIAL PROBLEMS

Since certain aspects of the program raise special questions they are considered in this section. The first of these is the internship.

Internship. What are the aims of a psychological internship? [5] Underlying all of its aims is the principle now recognized for the whole clinical psychology program, but particularly true for the internship, namely, that the knowledge essential to the practice of clinical psychology cannot be obtained solely from books, lectures, or any other devices which merely provide information about people or about ways of studying them. Rather, extensive and intensive experience *with* people is held to be essential if the student is to acquire a proper perspective and the ability to apply effectively the scientific facts and techniques which he has acquired in the academic setting. It should be pointed out that the internship is not a "repair shop" in which the failures of the academic center are taken care of. The university must

[5] The term internship (residence appointment) is used in this report interchangeably with externship (non-residence appointment).

adequately carry out its function of providing the necessary training in tool subjects so that the student may take the fullest advantage of what the internship is set up primarily to provide, namely, material on which to use these tools. Before he can become either a competent practitioner or investigator, the student must become sensitive to the many relevant aspects of the real person under actual study and learn to view him as an individual. In this process, he also learns to view himself as an essential instrument in the study of other persons. Because of the recognition of these needs, clinical clerkships and internships, the only devices that can accomplish these goals adequately, have been made integral parts of the program.

The major contribution of the internship is the provision of extended practical experience of gradually increasing complexity under close and competent supervision. The building up of an apperceptive mass of experience which gives concrete meaning to general principles can be attained only by volume and variety of contact with actual clinical problems in association with other disciplines. The program should provide the student with a broad base for later specialization by throwing him into full-time contact with human clinical material, contact of a much more intensive kind than he can possibly achieve during the clinical clerkships of the second year. This aspect of the instruction gains its value from being organized around the case material to be found in the institution, that is, the person rather than the condition is made the center of interest. Not only is the person seen in cross-section but it is possible to follow him longitudinally, either as the psychological processes develop and unfold, or as they may have been previously conditioned.

The content of the internship program comprises two major categories of activity: that involving contact with the patients or clients and that involving the acquisition of experience in the administrative sphere.

Contact with clients is of two types: *direct*—the acquisition of information from the patient by the investigator himself; *indirect*—the acquisition of information from and about the patient through other investigators and sources.

In direct contact with clients the main avenues of approach are those concerned with diagnosis and those concerned with disposition. Each of these requires separate consideration.

A most important aspect of the education of the intern is the further instruction he receives in the use of *diagnostic procedures,* the procedures directed at acquiring knowledge about the origin and nature of the patient's condition. Under this heading are included a great

variety of techniques of different levels of objectivity and degrees of complexity among which history-taking, interviewing, clinical psychometrics and analytic and projective techniques are of particular importance.

An equally important aspect of his direct contact with clients is that involving *disposition:* what is to be done about the presented problem on the basis of the findings obtained through the use of the various diagnostic procedures. The worker himself may be directly concerned with disposition or he may serve in the role of consultant. In the former, the direct execution of the implications of the diagnosis may be at a technical aid level, at a therapeutic aid level, or at a quite advanced professional therapeutic level. In the latter instance, when the intern acts as a consultant, the recommendations which frequently are part of a much broader set of recommendations deriving from studies made by several disciplines, are carried out by another person. In such a case the intern should have the opportunity to find out how effective are the actions taken with respect to the recommendations he has made, that is, he should at least be able to follow the case through written or oral reports. One of the advantages of the full-time internship is that the student is in a position to follow personally the evaluation and disposition made of the patient whom he has studied. A major disadvantage of part-time appointments is the likelihood of lapses in this follow-up process—the experience in too large a part consists of a succession of unclosed gestalten.

The direct contact with subjects just discussed lends itself to two different types of approach, each with a different end in view. The first is the *service* approach, that is, the study of the patient with the aim of solving his particular problem without regard for the general implications involved. Most of the work which is done by the intern is at this level. The second is the *research* approach, that is, the study of the patient not only for himself but for the general implications which his particular problem presents to psychology and psychopathology. This may be based either on a very thorough study of the client as an individual case or as a unit in a series of cases. Research experience, as has been indicated, is an essential part of the background of the clinical psychologist and a considerable part of the intern's time—perhaps up to one-third—should be devoted to the study of a problem on which he can accumulate a body of data during the course of the year's internship. This material, as suggested earlier, may very well be used for a dissertation. One of the most valuable contributions of the internship is the repeated opportunity which it affords for intensive team work, for intimate association with members of related disciplines

on specific cases and problems. Such practical opportunities for coordinated activity and thinking are indispensable for proper training.

In addition to these direct contacts with clients a considerable part of the instruction which the student receives involves only *indirect* contact with them, that is, is about patients with whom he himself has had no direct association. This includes experience of three kinds: (1) individual—about a particular subject; (2) general—about classes of subjects; and (3) technical—about methods used with such subjects.

Indirect contacts with *individual* patients may arise either within the setting of the institution's psychology department or outside the department. In the former are included conferences and department staff meetings which consider the diagnostic or therapeutic aspects of cases carried by other members of the department. In this type of relationship with clients the extra-departmental contributions are usually the more extensive. A major contribution to the student's education is the knowledge which he acquires from regular attendance at the institution staff meetings which consider patients for initial orientation, for diagnosis, for disposition, or for special pedagogic purposes. At these, the student has the opportunity to become acquainted with the contribution made towards the understanding of a case by other disciplines, such as psychiatry, social work, pediatrics, education, occupational therapy, or nursing, and the manner in which the various contributions integrate with the psychological findings.

Contact of the *general* kind, that is, about general problems and classes of subjects, is obtained by the intern both in and out of the institutional psychology department through lectures, courses, and seminars in one or more fields, such as psychiatry, psychosomatics, neurophysiology, experimental psychopathology, and re-education and rehabilitation, and in the approaches to the problems of clinical psychology from the standpoints of particular disciplines, namely, social work, neurology, psychiatry, internal medicine, pediatrics, education, pastoral work. The student thus continues his "academic" education in the setting of concrete material and personal day-by-day meaningful illustration. This education has the further advantage of being carried on without the interruptions which shifts back and forth in geographical setting entail. During the internship year opportunity is afforded for extensive seminar study of advanced techniques in therapy, and advanced work in diagnosis with such devices as the Rorschach and the Thematic Apperception Test, techniques about which only the first essentials are actually learned in the first courses which are taken at the university.

Another aspect of this indirect contact with patients is the instruc-

tion which may be provided in sessions which consider new *technical* procedures. Here, too, the emphasis should be on the exemplification of the techniques by case material from the clinical setting.

An important point which administrators of internship centers must keep in mind is the necessity for constantly providing experience with normal material. The institutional personnel, by serving as subjects in psychological experiments and tests, frequently offers a rich source in this respect.

There is one other type of experience which is of some importance. We refer to the *administrative* aspects of department activity, including the mechanics of relationships with colleagues, superiors, members of other disciplines, and the institutional administration. At the start of the course of internship the supervision should be close and the supervisor should assure himself of the ability of the student to handle even the simplest problems or procedures. As the student shows increasing competence, the supervision should be proportionately reduced and greater responsibility placed on the students to supervise each other with only a final check by the supervisor. The latter should, however, always be available for consultation. The importance of competent supervision cannot be overemphasized and any institution which accepts the responsibility of providing an internship program must recognize this as one of its important tasks. In the intra-departmental sphere each intern should carry some of the responsibility for departmental functions. This may be in the nature of assisting in the supervision of other interns (rotated regularly among the group), the teaching of students who are serving clinical clerkships, and the care of departmental records of patients.

A fundamental purpose which must lie behind the process of instruction of the intern is the gradual development in him, through judicious supervision, of a sense of a responsibility and self-reliance in handling clinical problems. The program as a whole should be organized to provide the student with increasing responsibilities commensurate with his growth in the ability to accept these. Such a task requires constant knowledge by the supervisor of the state of the student's progress through active contact; absentee, routinized, or overloaded supervision cannot achieve this goal. The optimum number of students that a supervisor can handle depends on the nature of his other responsibilities; in general, five is about right. As soon as possible, the student should become a productive staff member, one who contributes practically to the service activities of the department. Even if his contribution is limited, as it necessarily is at first, the psychological effect on the student in giving him a sense of respon-

sibility and a feeling of usefulness is great. Such contributions also make the administrators of internship centers more receptive to the establishment and maintenance of internship opportunities.

Another important aspect of the problem of the mechanics of instruction is the way in which the internship is organized. A full consideration of the various types (concurrent as opposed to block or consecutive, straight as opposed to rotating) leaves the Committee with the judgment that the block system, in which a full year is devoted solely to the work at the institution, especially that involving residence there, is to be preferred. As suggested earlier other forms should, however, be experimented with. For the present, too, it seems preferable to concentrate on the straight internship, if for no other reason than because of the much greater simplicity of its organizational aspects as compared with the rotating type. (In the latter the problem is complicated because the student has to move at intervals from institution to institution.) In the medical field rotation has in many instances been found to result in a "smattering of knowledge." This, as well as many other important aspects of the problem, is discussed in some detail in the Subcommittee Report (*4*), and should be referred to.

What kind of institution is to be preferred for the internship—child or adult, state or private, mental disease or mental deficiency, outpatient or in-patient? Careful consideration of the problem impresses the Committee that it is not the type of institution which should be the major determining factor but rather the nature of the particular institution. "Good" institutions, that is, those providing opportunities for diagnosis, research, and therapy with a reasonably varied population under adequate supervision, of any type are better than poor institutions of what might be considered a favored type.

These general goals can of course most easily be achieved in large training centers where various disciplines are represented. Too much training in psychology has gone on in starved environments and a change in this respect is long overdue. A major characteristic of the "rich" environment is that concurrent training is provided in a variety of related disciplines, such as psychiatry, social work, nursing and occupational therapy, as well as in psychology. For the latter, it is most important that at least the first two be represented. Such a setting provides the possibility for students of several disciplines to work jointly, under supervision, on common cases. Some of the most profitable learning about the case itself, about the relative and complementary contributions of the different disciplines, and about ways of working together effectively for the benefit of the client comes from

these contacts. Besides the appreciation of the complexity and many-sidedness of the problem which comes from the different philosophies and points of view which are ordinarily represented, there is considerable learning by example from the other disciplines. Instances of this are the appreciation of rigorous experimentation that is derived from the physiologist and biochemist, the appreciation of the importance of meaningfulness as represented in the systematic viewpoint of the psychoanalyst towards molar data, and the sensitivity to the practical social implications of a problem that comes from the social worker.

Optional Courses. Although the four-year program should have a common core for all those training in clinical psychology, and should in general be similar for all students in the program at a particular university, it is important that a certain degree of option for special courses be permitted. This can ordinarily be worked out most satisfactorily in the fourth year, but should be possible at other points in the program. One may expect that the concept of what constitutes desirable clinical training programs will change with the years and it is best to permit students, through elective courses, to do a certain amount of experimenting with their programs as one aspect of this search for the most satisfactory program.

Dissertation. Because of our interest in developing a research-oriented professional person it is quite important to retain the feature of the dissertation as part of the requirements for the doctorate. However, universities will have to rethink the whole question of the nature of the dissertation and its proper function, especially as it relates to the present type of program. With respect to its place in the proposed program, advantage should be taken of the opportunity provided by the internship to carry out a research project in the field of major interest to the student, both because of this interest and because it is important for him to obtain research experience in the clinical field. The student can learn as much about the nature and rigors of methodology and make an equally significant contribution to knowledge in working on some problem in personality or in psychopathology as he can in the more conventional fields. Although a dissertation on some aspect of personality which is based on normal subjects in the university laboratory should of course be acceptable, the Committee feels that preference should be given to projects involving clinical material since the student must receive as much training as possible in research with such material. The present program is so organized that research on clinical material could probably be carried out most economically in time if the internship period were utilized for this purpose. In the ordinary course of events, the student would, during his second year,

do whatever preliminary work was necessary on his dissertation: he would select the problem with the aid of the faculty and the supervisor at the prospective internship center, and draw up a project outline. If preliminary experimentation is necessary it might be possible to carry this out at the university or at one of the clerkship centers. During the internship year, the student would collect the data for the dissertation. Supervision of his project should continue a joint responsibility of the university and the field training center. When the student returns to the university for his fourth year of work, he would be in a position to do the final analytic work and writing.

It is our hope that as a result of the more extensive and careful selective devices which this program is advocating, the dissertation will become much less of a major hurdle than it has heretofore been. As in professional schools, the student should by the end of the second year be so certain of having been carefully screened and of having met the requirements as to capacity and achievement, that, given conscientious attention to the balance of his program, there should be little doubt about his completing the course. The development of such an atmosphere would do a great deal to reduce the anxiety with which the latter part of the PhD program is so heavily laden, an anxiety which is largely created by the multiple and generally illogical uncertainties connected with the dissertation. If such an atmosphere can be developed the productivity of students during this period would certainly become greater.

Integration of Academic and Field Program. After what has already been said in different sections of this report it is unnecessary to discuss further the importance of integrating the two parts of the program. The techniques of implementation, however, require additional consideration. The problem of integration arises with respect to three aspects: (1) content, (2) supervision, and (3) accrediting and certification.

For the program to be most effective the content provided by the two teaching centers must be well integrated. In this respect, faculty members have in the past been quite lax. They have left too much to the student the task of correlating and integrating the material in the variety of courses which he has taken at the university. The integration of university and field center activities has been neglected even more. If training is to be optimally effective, strenuous effort will have to be directed at correcting the situation. In order to achieve such integration the whole group must become essentially *one* faculty. Arrangements for reciprocal visits and conferences between the staffs should be made to discuss such problems as the points of view to be empha-

sized, the techniques of teaching, and the avoidance of overlap. It is most important for the instructors at each place to know the general content of the teaching at the other. Such mutual acquaintance would go far towards making easier for the student the tranisiton to the internship center and back to the university.

In the matter of supervision an integrated program must also be achieved. The supervisor at the internship center must obviously be held responsible for the major part of the student's activity. If the candidate is to use his available research time at the institution for work on his dissertation, a very close relationship between supervisors and agreement as to the division of supervisory responsibilities must be achieved by the two groups. The appointment by the university of several of its instructors, on a rotating basis, to act as field supervisors should be considered. It would be their responsibility to hold scheduled conferences with the interns in order to maintain contact with them and help supervise their dissertations.

All of the aspects requiring integration point to the obvious need for a combined responsibility in setting and maintaining standards. Such unification can only be achieved by accepting the internship center as an institution of comparable status with the university and in some respects an integral part of it. This can be achieved by interchange of personnel, joint conferences, and by interchange of student visits. There is no better way of achieving integration than through an interchange of staffs. The teaching staff of the university should be encouraged to spend summers or other periods at the institution on guest appointments. The staff of the institution should be given temporary full-time or permanent part-time appointments at the university on a regular faculty or lectureship basis. The latter arrangement is generally quite practicable and does not become too involved in the problems of university administration.

Self-evaluation. As psychologists become more involved in the clinical field, they become increasingly impressed with the importance of the observer as instrument. An important aspect of this problem, one which arises particularly in dealing with motivational questions, is the degree to which one's own biases, affects, and problems, frequently only different from the patient's in intensity, color the material provided by the patient. It has become obvious to those working in the clinical field that some kind of control of this source of error is necessary. Psychiatrists and social workers, from their more extended experience with this type of material, have long accepted the principle of the need for intensive self-evaluation as a prerequisite for their work, especially their therapeutic work.

Psychologists, in our opinion, must come around to the acceptance of some kind of intensive self-evaluation as an essential part of the training of the clinical psychologist. We are not prepared to recommend any special form of such procedure, although some of us believe that whenever possible this should take the form of psychoanalysis because of its relative completeness. Others of us believe that shorter methods of self-evaluation, because they may be less time-consuming and less indoctrinating, are preferable. Whatever the form, training should include detailed self-examination under the competent guidance of persons relatively free from dogma who have an interest in psychological theory as well as in therapy.

Psychologists can adopt from social work practice a procedure that has been found effective in achieving at least partial self-knowledge. We refer to their use of detailed case supervision of students. As a result of almost daily contacts with the student on his own cases a relationship is established between the sensitive supervisor and student which may indirectly have therapeutic benefits. Such a setting makes it possible for the student to examine critically his own behavior and interpretations as they grow out of his handling of case material and provides an opportunity for considerable personal growth. The profit from these personal contacts is increased when backed up by classroom discussion of cases on a less personal motivational basis.

Administrators of training programs should make an effort to promote such supervisory practices and canvass the possibilities for the more intensive type of self-evaluative experience in their own regions. Students, during the last part of their doctoral training, or immediately after this training, should be encouraged to undertake such a program.

Professional Responsibilities. No group can become a profession overnight, a fact which clinical psychology is in the process of discovering. What really counts in the making of a profession—professional ideals and practices—cannot unfortunately be taught in courses. Proper technical training, professional certification and state certification, of course, play important roles. More important, however, are identification with a group having high ideals, and constant association in the actual work situation with persons having professional goals. It is in the work relationship that the student can learn to think of himself as a professional person. It is here that the student can gain an appreciation of how people meet such problems as maladjustment, illness, and handicaps and in this context gain a feeling of responsibility about his work because he understands that his findings really make a difference in what happens to a particular individual and his

family. It is here that he learns to carry, in addition to this responsibility for the individual, the broader social one which transcends the need of the individual patient. It is in this setting, too, that another important aspect of professional training, his relationship with other professions, is constantly brought to his attention. He learns the techniques and importance of the group attack on problems: how best to work with other professional groups for the benefit of the individual client and the frequent necessity for identifying himself with a group even broader than his own professional group, namely, the "team."

If the student, after having achieved strong identification with psychology, learns to divest himself of this identification in order to become part of larger wholes for the benefit of a patient or a group, then he may be said to have achieved true professional growth. It is in this setting that ethical problems constantly arise and that the greatest learning in dealing with them naturally occurs. When this opportunity for "field" learning has been afforded, then "talk" learning becomes profitable. Seminars on professional and ethical professional problems have a contribution to make and should generally be made available during the fourth year. In these courses the ethical problems that arise from relationships with clients, and those that arise from relationships with other psychologists and with other professions and the public should be considered, especially as they develop from concrete situations.

Student Relationships. We have stressed, in one context or another, the importance of the development of a sense of responsibility. Such a sense comes only in proportion to the opportunities for practice afforded a person. Besides those we have already discussed, another area where students may exercise responsibility is in helping to shape the program in which they are enrolled. Such thinking about professional problems, whether group or individual, should be encouraged, as should the organization of colloquia which the students themselves administer. The opportunity to express themselves freely on policy will insure reduction in the dissatisfactions and irritations which naturally arise in any program.

Another aspect of this problem has to do with the individual problems of the students—whether personal, or connected with the program. Provision should be made for adequate conferences on such problems when they arise. In fact, each student should have an active advisor whose responsibility it would be to keep track of the student's progress and who would be readily available to consider his individual problems.

Evaluation of Accomplishment. A problem which necessarily follows

the organization of a program such as the one outlined is that of accrediting and certification, that is, the official recognition of the adequacy of those who take part in it—the student, the university, the field center.

For the student, at the various levels of individual advancement, some appropriate symbols of achievement seem necessary. The following are suggested:

1. Doctoral degree following the four-year course of professional preparation. Although there are some professional groups, notably the legal, which practice on the basis of a bachelor's degree, there are various considerations which make it doubtful if anything less than a doctoral degree would be satisfactory for the practice of clinical psychology.

2. Membership in the special division of the professional association of the group, the American Psychological Association's Division of Clinical and Abnormal Psychology. The first grade of active membership, Associateship, as recommended by the Policy and Planning Board (*2*), would come for participants in this program, with the attainment of the doctorate; the second, Fellowship, with an additional five years of acceptable experience—essentially at the level of diplomate as discussed later.

3. After a year's post-doctoral experience would come state certification as recommended in the Policy and Planning Board Report (*2*). Closely linked with the problem of study beyond the doctoral degree is that resulting from the establishment of the American Board of Examiners in Professional Psychology (*3*). This Board has as its function the certification of candidates who after five years of actual experience, three years of which have been spent in recognized training centers, have passed examinations in stated aspects of the field of clinical psychology. (The nature of this advanced residency type of training requires special consideration and is not directly pertinent to the present problem. We hope to consider the matter in a later report.) Diplomas of the Board would serve as evidence of competence in the specialty of clinical psychology. Such a program emphasizes the important point that the attainment of the doctoral degree is only a step in the process of professional education, an education which continues through to specialist rating and beyond; in fact, throughout professional life.

Training universities and field centers as well as students must be evaluated. The universities should be evaluated according to their ability to meet the requirements set forth by this program. (Our Committee has been charged with such an evaluation and hopes to be able

to commence this task shortly.) Not only the formal meeting of standards with respect to the courses given but the actual quality of the courses, as it relates both to content and instruction, should be carefully scrutinized.

The field centers should be given the same careful scrutiny as the schools. Standards as to content, quality, and amount of supervision, facilities (personnel, clinical, library, teaching), and living arrangements, should all be carefully set up and used in the evaluation. Since it is likely that the degree of expansion of clinical psychological training will depend to a great extent upon the number of really adequate internship centers which are available, considerable effort should be directed by universities to encouraging their development.

RECOMMENDATIONS

The Committee on Training in Clinical Psychology believes that the program outlined in the present report, if effectively carried out, should provide the basic background for clinical psychologists who will undertake both teaching and practice functions in the diagnostic, therapeutic, and research aspects of the field. This program, it believes, should also prepare persons who can eventually contribute to its preventive aspects, a goal towards which more and more of our future efforts must be directed.

The Committee on Training in Clinical Psychology therefore recommends to the Council of Representatives:

1. That the present report be endorsed.
2. That the program here outlined be presented to the universities offering doctoral training in clinical psychology as a recommended program.
3. That the report be recommended for publication in The American Psychologist.

Respectfully submitted,

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