PhD Training in Clinical Psychology: Fix It Before It Breaks

Linda W. Craighead and W. Edward Craighead, Department of Psychology, University of Colorado

During the past 60 years clinical psychology training programs have made remarkable changes as psychologists' professional roles and scientific contributions have emerged. Yet, there are a number of issues that have implications regarding the quality of research training in PhD programs. Current PhD programs are encouraged to offer a joint PsyD/PhD training program when their goal is to train researchers and clinicians who would be eligible for licensure. It is recommended that the PhD serve only as a research degree. A joint PsyD/PhD addresses many of the identified problems and issues. It conserves resources for research training and explicitly identifies, recognizes, and rewards the training that is required. It may best serve to advance the knowledge base of clinical psychology.

Key words: **accreditation licensure, joint PsyD/PhD, training models.** ***[Clin Psychol Sci Prac 13: 235–241, 2006]***

Current controversies swirling around the accreditation process for clinical psychology training programs simply highlight more basic problems and issues that have been simmering for more than a decade. It is time to address these issues and devise an alternative that can bring research and practice into an effective and collaborative partnership. During the late 1980s and early 1990s the current accreditation system evolved to ensure that it operated at "arm's length" from psychology's primary professional organization—the American Psychological Association (APA). Therefore, the current Committee on Accreditation (CoA) functions under the aegis of the APA Board of Educational Affairs (BEA) rather than the APA Council and Board of Directors. Within the current accreditation system, each training program defines its own model and is supposedly evaluated according to how well that model is implemented. One of the driving forces for developing this system was the perception that a "checklist" mentality had developed within the previous accreditation system. The goal of many PhD programs is to provide both clinical and research training, but they often believe that this dual goal is not taken into account in evaluating their programs and that certain requirements unduly restrict their ability to provide the best type of combined research/clinical training. In recent years, many PhD programs perceive there has been a swing of the pendulum back toward a checklist mentality, with increased course requirements deemed necessary by professional practice standards, state licensing boards, and the CoA. Once again, concerns have been raised that accreditation requirements make it excessively difficult for PhD programs to establish the type of training they believe will produce the highest quality clinical scientists. Differences over how standards are to be interpreted and applied among different programs lead to further antagonism between the research-oriented academic training programs and the more practice-driven programs. Furthermore, recently suggested structural changes for the CoA (emanating from the BEA and the report of the BEA Advisory Council on Accreditation in November 2004) are likely to weaken further the role of academic clinical psychology programs and departments in determining the content of the training programs they develop and direct. This process and the reorganization of the CoA are still being debated (see, for example, the 2005 Inter-Organizational Summit on Structure of the Accrediting Body for Professional Psychology; report available at

Address correspondence to Linda W. Craighead, Department of Psychology, University of Colorado, D244 Muenzinger Building, UCB 345, Boulder, CO 80309-0345. E-mail: lindac@psych.colorado.edu.

www.psych.wfu.edu/COGDOP). The implications for who determines the content and processes of doctoral programs in clinical psychology are enormous.

In addition, the Academy of Psychological Clinical Science is planning an alternative accreditation system for the more scientifically based PhD programs in clinical psychology. This underscores the extent of the difficulties associated with the current accreditation system. Nevertheless, it seems likely that separate accreditation processes would further widen the schism between science and practice.

In addition to concerns over accreditation, there are a number of fundamental issues facing PhD clinical psychology programs in academic departments of psychology. Rather than just enumerating these issues, we will identify them within the context of the development of the profession and training programs, and then propose a model for doctoral training that we believe would be a positive way to advance the field.

CLINICAL PSYCHOLOGY'S EVOLUTION AS A PROFESSION

Over the past 60 years, clinical psychology has come of age as a profession of mental health providers, and it has also significantly expanded its role as a field of scientific inquiry. Clinical psychologists are now major players in the field of mental health service delivery. Clinical psychology has also taken a major role in developing and evaluating theories, psychopathology, assessment, and interventions (both prevention and therapy). Findings from these research endeavors are increasingly utilized by other mental health providers as well as clinical psychologists.

Following the Boulder Model, university PhD programs were, early on, ideally suited for the task of training individuals who could apply psychology research in the clinical arena. They faced limited issues of certification and there were virtually no licensure procedures in place. However, as in the development of other professions, the increased professional roles for clinical psychologists soon necessitated a system of licensure to protect the public, identify legitimate providers, establish a system to monitor the provision of services, and provide a way to deal with ethical issues, fraudulence, and impaired individuals. As in other developing professions, initially the criteria for licensure for clinical psychologists varied widely across states, and various doctoral degrees were acceptable. As professions mature and develop their own processes for accrediting training for the profession, state boards increasingly look to the profession to identify minimum standards for licensure. Accepting a profession's identified accredited training as the standard simplifies the credentialing process for state boards, reduces confusion for consumers, and enhances the ability of those professionals to move freely within the country.

As this credentialing process occurred within clinical psychology, APA emerged as its voice. Early on, APA strongly endorsed the use of the doctoral (rather than the master's) degree in psychology as the basis for identifying individuals eligible for independent practice. In this spirit, APA subsequently endorsed the PsyD degree, when it emerged, as an alternative equally acceptable for licensure. Notably, psychology's decision was different from the one made in the field of social work, which endorsed the master's (MSW) as its practice degree, reserving the PhD for the more limited number of researchers and academicians. As a result, the master's of psychology degree has been relegated to an uncertain status, creating serious issues of its own.

APA's decision to support requiring the doctorate for licensure reflected the strong sentiment among clinical psychologists that it would be advantageous to retain its stronger emphasis on research training. This served as an important way to distinguish clinical psychology as a profession. On the other hand, the PhD took on a dual role, becoming a professional degree as well as a research degree. This situation means that such programs are something of an anomaly within university-based psychology departments. In such departments, PhD students are typically fully funded during their training; this is different from models of professional training in which trainees bear the financial burden. In an era of financial constraints on education, the costs of providing professional training and meeting accreditation requirements (such as sequencing courses, providing practica, and offering many small graduate seminars) make clinical psychology programs expensive and this is frequently misunderstood or not well tolerated (Calhoun & Craighead, 2006). Thus, there is constant pressure to admit only a small number of clinical students and reduce the number of graduate seminars as well as challenges to paying adequately for practicum training, and questions about the necessity of clinical training clinics and their associated staff.

In spite of these issues, PhD psychology training programs have made remarkable changes as they evolved to meet the dual challenge of professional and research training. Of course, much of this training occurred during a period when the National Institute of Mental Health and the Veteran's Administration system provided significant funding for these programs and the required internships. PhD programs trained virtually all of the doctoral-level clinical psychologists until recent decades, during which the number of PsyD programs has dramatically increased. The majority of these PhD clinical psychologists became mental health providers whose careers did not actually involve significant continued engagement in research. Even now, most research-oriented programs find that not all students go on to primarily research/teaching positions.

PhD-trained clinical psychologists did an amazing job of establishing clinical psychology as a professional identity separate from other mental health providers. However, this success ultimately fueled demand for this kind of training that was far beyond the capacities of the available PhD programs. Professional clinical psychologists were being well paid, so the profession was attractive and individuals became increasingly willing to pay for their training.

Unfortunately, universities and their psychology departments (with a few notable exceptions) did not rise to the occasion and make provisions for larger, "professional" psychology programs under their auspices. Thus, while professional training in medicine and law developed largely under the umbrella of traditionally accredited universities, freestanding PsyD programs emerged to fill the demand for licensed clinical psychologists. This development, while meeting the need for more practitioners, has been a major contribution to the schism that developed between research and practice that is at the root of many of the field's current training and accreditation issues.

The current situation creates difficulties for both PhD and PsyD programs, which could be addressed in a more effective way that would move the field in a positive direction. We must update our training models to provide highly skilled researchers who can further the field, but we must also be able to train adequate numbers of providers who, like in medicine, understand and are committed to evidence-based practice (APA Task Force on Evidence-Based Practice, 2006). The medical profession's evidence-based model of training is an alternative that bears serious consideration. Psychology can emulate this general training framework without accepting (or rejecting) the so-called medical model of treatment. Medicine recognizes that a doctoral level of training (the MD) is needed for independent practice, but that a research degree (a PhD) is not necessary and is not practical for practicing physicians. Although a PhD is highly valued for research purposes, it does not in and of itself ensure that standards for the practice of medicine have been attained. Thus, joint degree programs are available for those who want additional training in research within a particular academic program. In this scenario, the professional degree has a clearly identified value. However, the PhD confers added value by identifying those who are also highly trained in research methods. There is no expectation that MDs "should" be conducting the research, but they are clearly expected to "use" the research. MDs are not actually prohibited from engaging in research since research is not a licensed activity. However, only those who find they truly have the aptitude and desire seek out additional training or participate in formal PhD programs. Joint MD/PhD degree programs in medicine remain highly desirable and attract applicants with the most potential for research without detracting in any way from the legitimacy and desirability of the standard MD programs. Indeed, the two types of programs coexist quite comfortably within the same medical schools, and accommodations are made to take into account the special needs of students in the joint program. This model appears to promote the mindset that practitioners are trained to be able to read and use research, and that they are obligated to stay "up to date" with advances in research.

Allowing two different degrees (PhD and PsyD) to serve as the standard for entry to practice blurs the distinction between standards for practice and standards for research. In addition, it promotes unhealthy competition, divisiveness, and defensiveness between groups who should both be working toward the same end—more effective service to the public. We believe that most PhD training programs are *de facto* serving as joint degree programs without adequate recognition of the added costs and the added value of providing intensive research mentorship. Within this scenario, it is no surprise that

potential students tend to opt for the more "flexible" PhD option without careful consideration of the additional demands associated with obtaining a research doctorate. Students have no motivation to truly assess their commitment to research when PhD programs provide funding while PsyD programs do not.

The current situation places a heavy burden on PhD programs and has made it difficult for programs to take the steps necessary to strengthen the quality of their research training. Enormous strides made in statistics, methodology, and technology mean that research training that was adequate a decade ago is no longer sufficiently intensive or interdisciplinary to train cutting-edge clinical scientists. Furthermore, due to the more specialized skills required, it has become increasingly difficult to evaluate motivation and aptitude for research early in a clinical student's career. Meanwhile, the increased workload necessary for accomplishing competency in practice compromises the effort and time available for students to engage in research training.

In addition, the current requirements for supervised postdoctoral hours necessary to sit for licensure are problematic for all graduates of both PsyD and PhD programs, but they are particularly problematic for those who would like to go directly into the academic job market after obtaining the PhD. Clinical training programs often want their new faculty to be licensable in order to conduct supervision of clinical practicum training. In most states, teaching and research can meet some of the required postdoctoral hours, but typically at least 1,000 of the hours must be in clinical service. Given the demands on new faculty for teaching, research, and professional and community service, completion of such hours is a most demanding task. Postdoctoral positions have often been able to fulfill that purpose for many new PhDs, but finding positions that meet individuals' need for advanced research training in a particular area as well their need for supervised hours is not easy.

For all the reasons just enumerated, we believe it is time to take a hard look at the entire process of doctoral training in clinical psychology and its relationship to licensure, and to consider alternative models.

PROPOSAL TO ESTABLISH JOINT PSYD/PHD PROGRAMS

In order to address the problems associated with having two doctoral programs serve as the standard for entry to professional practice, we propose a fundamental modification to current training in clinical psychology. The details of implementing such a model cannot be laid out in this brief article, but the overall framework will be described. If this framework attracts interest, then detailed plans could be developed and their merits debated.

The major tenet of the model is a reformulation of the current distinction between the PsyD and PhD. We propose that the PhD be returned to its role as a research degree, certifying only that the individual has demonstrated a high level of competency in the research domain. The PsyD would become the only professional degree. We also recommend that the profession strive to identify more reliable and valid assessments of therapist competency so that the PsyD would be strengthened and would clearly certify "initial" competency to practice. This would eliminate the need for troublesome, unregulated postdoctoral supervised hours. It would also address the pressing need to evaluate competency for practice in a reliable and meaningful way.

A proposal to make the PsyD the practice degree was previously put forward by Shapiro and Wiggins (1994). Their proposal, however, was based primarily on the need to reduce confusion for consumers. These authors did not specifically discuss the possibility and distinct advantages of encouraging current PhD programs to become joint programs. Instead, this proposal advocated for a complex system of awarding (unearned) PsyD degrees to previously licensed PhD clinical psychologists. Thus, the concept of establishing a uniform professional degree was lost in the controversial, practical matter of having to assess credentials and figure out how to award the PsyD degree to all individuals currently licensed as PhDs. Furthermore, that proposal was caught up in a number of other APA political issues surrounding the now somewhat infamous Joint Commission on Professional Education in Psychology.

In our proposal, currently accredited PhD programs would be permitted to become accredited joint PhD/PsyD programs. Then, clear minimum standards for the professional degree could be established and applied uniformly. Establishing separate accreditation processes for clinical, counseling, and school psychology would make this model of training even more compelling as differences among these disciplines have also contributed

significantly to PhD programs' concerns regarding accreditation. Complete control over the PhD degree would be returned to the academic departments, addressing many of the other current conflicts related to the accreditation process. Individuals who earn both degrees would have a clinical license and be clearly prepared to train and supervise clinicians as well as develop and evaluate interventions. We anticipate that many of the current PhD programs would choose to become joint programs, but some may not. A PhD–only program would be free from the need to conform to professional accreditation processes; they would be offering a traditional PhD research degree under the university's regional accreditation process. PhDs who preferred to focus on research could collaborate with PsyDs, MDs, and others who would be responsible for supervising the clinical interventions that were being evaluated.

Making such a significant change in the accrediting process will not be without difficulties and issues of its own. However, the current system is already being challenged. Any alternative system is also going to take several years and a lot of work and money for successful implementation. We believe the proposed model would be less divisive and do more to move the field forward in a unified manner.

ADVANTAGES FOR PHD PROGRAMS

One significant benefit for current PhD programs is that it would reduce the pressure for all admitted students to continue with research training, regardless of their evolving skills and life goals. The reality is that no one can reliably predict at entrance to graduate school who will embrace the research path. Perhaps we should not even expect students to be able to make such a binding decision at that point in their lives.

There are many options for the specific details about how a joint degree program would work. One possibility is that the first two years remain essentially unchanged. Students would complete coursework and start clinical practicum. There would be little need to require an official master's degree but specific, graded research requirements would be spelled out. It is envisioned that the PsyD (including the internship) would take a maximum of five years. Those desiring to continue with research would then have another year or two to complete their dissertation and receive the PhD in a joint program.

Students who find out during their first few years that they are not motivated for (or do not have a strong aptitude) for research would only receive the PsyD. This is both the humane and the effective way to resolve a difficult problem of what to do with PhD students who decide only to be clinicians and do not wish to pursue a research career. Terminating such a student at the master's level is a huge professional penalty. Thus, research mentors frequently end up spending an inordinate amount of time helping these students get through dissertations that do not contribute much to the field or lead to a program of research. The option to stop after receiving the PsyD resolves this problem.

Research training for the PhD, by its very nature, must continue to be done within the expensive and intensive research mentor model. In this model, valuable research mentorship time can be more effectively used for those students who continue toward the PhD, and their additional skills will be more clearly recognized by the awarding of the additional degree.

The joint degree model we propose is only one possible option, but we believe it could be phased in without further exacerbating the conflict between competing forces within clinical psychology. Both PsyD and PhD programs would accrue benefits and neither gives up much. The PsyD takes on a clear role, eliminating confusion in the eyes of students and the public, and reducing competitiveness between types of degree programs. Current PhD programs achieve the flexibility to confer either, or both, degrees as warranted by each individual's skills and evolving career goals. This move might even encourage traditional universities to take on a larger role in training professional clinical psychologists, as the financial picture might become more favorable. If so, this would encourage a closer link between science and practice as seems to be the norm in medicine. We believe this training model would enhance current PhD programs' ability to attract the most promising students to the clinical research path. Fewer students might choose to obtain both degrees, but those ending up with both would likely have greater potential to move the field forward and would be more easily identified as having an enhanced skill set.

Consistent with proposals by Borkovec (2004), we expect this proposed model would, in fact, facilitate the integration of research and practice at all levels of

training. He says, "New graduate students enter their program and discover from the first day in the clinic that science and practice are completely integrated . . . . Clinical psychologists growing up professionally within such a world would always see themselves inherently as 'scientist-practitioners.' In fact, eventually the term would disappear altogether as redundant with 'clinical psychologist'" (p. 215). This would likely promote the dissemination of evidence-based treatment from training settings to real-world settings. We need not fear that this model would further dilute the empirical orientation of PsyD programs. The medical profession, which uses this model, is, in fact, leading the way by embracing evidence-based medicine as the standard in its MD programs. The pressure to be accountable from insurance, industry, government, and the public will continue to push clinicians toward evidence-based practice.

ROLE OF INTERNSHIPS WITHIN THE PROPOSED MODEL

Both PhD and PsyD programs are currently quite dissatisfied with the inadequate number of current internship options. Since more students are seeking predoctoral internships than internship positions available (typically 300–500 per year; Keilin, 2006), programs can no longer assure students that they will be able to meet this requirement for their degree. Being larger in numbers and less well established, PsyD programs currently bear the bulk of this pressure, but PhD programs are also beginning to feel the pinch.

The most significant problem for PhD programs is the way this pinch affects their students' commitment to research activities. Students know they are competing with other applicants and believe (in many cases, accurately) that internships value clinical experience more than research credentials. Thus, PhD students feel pressure to exceed the minimum requirements of internships. They now complete many more preinternship hours of clinical activity than was previously considered necessary. Furthermore, *some* internships are lagging behind in changing their requirements to match the shift in theoretical models that has occurred within most PhD training programs (Norcross, Karpiak, & Santoro, 2005). Thus, some PhD applicants feel pressure to obtain training in models and methods no longer emphasized in their programs. This latter issue is gradually being resolved as more recently trained clinical scientists emerge as leaders in Association of Psychology Postdoctoral and Internship Center settings. However, the sense of urgency to accumulate excessive numbers of supervised hours in order to be assured of success in the internship application process continues to be a real and current issue. The entire application process has become even more time consuming so that it seriously compromises the time that students can devote to research activities. This is occurring at a time when potential researchers must attain an even higher level of statistical expertise than before and must learn difficult grantsmanship skills.

The proposed joint degree model would not *require* changes in the internship system, but it might encourage a currently minor trend toward "captive" internships, those in which a training program affiliates with an internship to provide slots for their students. Captive internships would be a particular advantage for joint degree programs as the program would be able to ensure the integrity of the entire training process. We find it increasingly unacceptable that PhD training programs maintain a requirement (the internship) that they cannot ensure students will be able to complete even when they remain in good standing.

TRAINING PROGRAMS AND LICENSURE

The proposed model also asks clinical training programs to take greater responsibility for developing and implementing reliable and valid methods to certify clinical competency. This is needed both to reduce reliance on quantity of clinical hours in the internship process and to reduce the need for state boards to maintain requirements for supervision over and above the accepted degree. PhD and PsyD programs both have a vested interest in working toward a system in which graduates would immediately be eligible for licensure in all states. In some ways, there is more pressure on current PsyD programs as those programs are selling a product—clinical training—for which there needs to be a clear payoff. However, current PhD programs would benefit from being able to certify clinical competency in a clear and efficient manner so that they might conserve time and resources for their other priority: research training.

Thus, there are compelling reasons for the field to tackle the obviously difficult task of assessing clinical competency. Such a discussion is beyond the scope of this article, but it is worth noting that two groups of

investigators are currently working on clinical rating scales that hold promise as methods to evaluate competency during graduate training and internship: the Treatment Outcome Package by Behavioral Health Laboratories—see Borkovec (2004) and Lambert's Outcome scale (see Lambert et al., 1996). Mechanisms such as this, or ways to certify competency with specific interventions or approaches, would have significant value. They would provide alternatives to the current reliance on accumulated hours and supervisor ratings. Ultimately, such a system would increase public trust in clinical psychologists' skills as there would be more uniform expectations about their skills and the treatments they would be providing. If programs fail to do this adequately, private enterprise will fill the vacuum. Already, developers of empirically supported treatments are being approached by insurance companies and other payers to establish credentialing processes that would serve to assure them that therapists are, in fact, providing the specific clinical services the companies are willing to reimburse and that therapists have been adequately trained to provide those services. If the field fails to address this issue proactively, free enterprise will take over and the matter of certifying clinical competency will be further taken out of the hands of accredited training programs.

SUMMARY

An alternative model of doctoral training in psychology is proposed. The PsyD would become the practice credential and the PhD would be earned by those pursuing a research career. Current PhD programs could become joint PsyD/PhD programs. This model takes the CoA out of the role of accrediting research training (the PhD degree) so it can focus on establishing reasonable and reliable standards for accreditation of the practice degree (the PsyD). By clearly identifying the PsyD as the standard for practice, the model has the potential to eliminate the vexing problem of postdoctoral supervision required for licensure for independent practice. By separating issues related to standards of competency for clinical practice from those of research, it resolves the difficult problem faced by current PhD programs wherein both standards must be met. The model allows for the development of a totally integrated clinical training program that could include practicum and internship. Most importantly, this approach has the potential to promote the development and dissemination of evidence-based practice of psychology. Establishing the highest level of research training will ultimately address the overriding concern that training in clinical psychology continues to reflect its evolving knowledge base.

REFERENCES

APA Presidential Task Force on Evidence-Based Practice. (2006). Evidence-based practice in psychology. *American Psychologist*, *61*, 271–285.

Borkovec, T. D. (2004). Research in training clinics and practice research networks: A route to the integration of science and practice. *Clinical Psychology: Science and Practice*, *11*, 212–216.

Calhoun, K. S., & Craighead, W. E. (2006). Clinical psychology in academic departments. *Clinical Psychology: Science and Practice*, *13*, 278–281.

Keilin, G. (2006, February 27). Match news: 2006 APPIC match statistics. Message posted to APPIC match news list, retrieved June 2006, from http://www.appic.org/email/8_2_email_archives.html.

Lambert, M. J., Hansen, N. B., Umphress, V., Lunnen, K., Okiishi, J., Burlingame, G., et al. (1996). *Administration and scoring manual for the Outcome Questionnaire (OQ 45.2)*. Wilmington, DE: American Professional Credentialing Services.

Norcross, J. C., Karpiak, C. P., & Santoro, S. O. (2005). Clinical psychologists across the years: The division of clinical psychology from 1960–2003. *Journal of Clinical Psychology*, *61*, 1467–1483.

Shapiro, A. E., & Wiggins, J. G. (1994). A PsyD degree for every practitioner. *American Psychologist*, *49*, 207–210.