

Curriculum and training reform in clinical psychology: Improving the integration of science and practice

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Abstract

Current graduate curricula do not fully grapple with and take advantage of the dialectical interplay of science and practice that is at the core of the scientist–practitioner (Boulder) model. This article addresses factors that interfere with the realization of the Boulder model and offers suggestions for curriculum reform. It emphasizes the importance of both science *and* practice, as well as the merit of both nomothetic and idiographic approaches to clinical training. The article discusses how academic politics often interfere with the incorporation of empirically supported treatments or assessment methods into training programs. Even when evidence-based approaches are a part of the curriculum, the challenges continue. Because empirically supported treatments are almost always associated with treatment manuals that rely on categorically defined diagnostic categories, they may inadvertently discourage idiographic functional analyses and the appreciation of underlying change principles. In addition, in light of the fact that many, if not most, students eventually pursue applied careers and because science-based interventions and assessment methods are currently underused by clinicians in the field, it is argued that clinical training should receive more recognition in scientist–practitioner programs. Programs should be mindful of the need to prepare a certain subset of interested students for scientifically based careers in applied settings. This article also highlights the importance of educating and training students in communicating and disseminating science-based clinical psychology to nonacademic psychologists and health professionals from other disciplines.

Key words: Boulder model, Curriculum reform, Empirically supported principles of change, Empirically supported treatments, Integration of science and practice, Scientist–practitioner model

In the post-World War II era, the scientist–practitioner model, also known as the “Boulder model,” has emerged as the predominant model for educating and training clinical psychologists. The majority of university-based clinical psychology programs, as well as a large number of internship training sites, subscribe to this model. Its philosophy holds that clinical psychologists should be educated first as scientists and second as practicing professionals. The model further provides that findings from controlled research should provide clinical psychologists with the main clues to understanding psychopathology and the basis for devising and evaluating the most effective and most efficient interventions and assessments.

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So far, reality in many training programs has fallen short of the lofty goals of the Boulder model (Davison, 1998). This is regrettable because a variety of developments, including the movement to define and designate empirically supported treatments and assessments, have provided the contingencies for a successful integration of science and practice. These days, realization of the scientist–practitioner model should be more feasible than ever before. As Hayes, Barlow, and Nelson-Gray (1999) note, managed care plays an important role in the encouragement of more scientific approaches to clinical psychology. In particular, an increased demand for accountability motivates practitioners to back up their methods with data. In other words, managed care is encouraging greater transmission in *both* directions between the lab and the clinic.

At the same time, training programs face a number of challenges that make the integration of science and practice difficult. This article comments on some of the challenges inherent in implementing the Boulder model and offers ideas for curriculum and training reforms. Throughout we argue

that an increased appreciation and integration of *both* the science and practice aspects of the Boulder model present training programs with the chance to improve a discouraging situation. Specific suggestions that argue for the importance of both nomothetic and idiographic approaches aim at facilitating the translation of our recommendations into the realities of graduate curricula.

Importance of Empirically Supported Treatments and Assessment Methods in Scientist–Practitioner Training Programs

In recent years, it has been repeatedly emphasized that empirically supported treatments (ESTs) and other scientifically based procedures should constitute an integral component of Boulder model training programs (Calhoun, Moras, Pilonis, & Rehm, 1998; Davison, 1998). Assessments and treatments based on empirical evidence provide a useful example of the interaction of science and practice that is the hallmark of the Boulder model. Hence, in terms of curriculum and training reform in clinical psychology, the implementation of ESTs into existing training programs should receive the highest priority. At the same time, the argument can be made that procedures that clearly lack empirical justification have outstayed their welcome and should be removed from curricula.

The Challenge of Adopting Empirically Validated Procedures into Curricula

The obvious relevance of ESTs and other empirically supported procedures to the goals of the Boulder model beg the question of why more has not been done in terms of reforming curricula toward a more empirical basis. The answer may be related to the numerous obstacles inherent in incorporating ESTs and empirically supported assessments of psychopathology into training programs.

Calhoun and colleagues (1998) provide an overview of the challenges of making ESTs available in training programs. Most important, they point out that it takes time, energy, and determination to overhaul a curriculum. In addition, Davison (1998) has commented on the interpersonal hurdles to bringing ESTs into training programs. He points out that many graduate courses exist out of deference to tradition or to the special interests of one or another faculty member. Changing the curriculum to implement approaches that enjoy more empirical support can turn out to be a sensitive issue, especially when dealing with senior faculty members. In addition, making training in ESTs and empirically supported assessment instruments a part of the curriculum would in many cases mean that faculty members themselves, as well as outside supervisors, need to acquire new skills and knowledge, something that one would think could be achieved via continuing education. Clearly, intradepartmental politics can easily short-circuit many such efforts. In order to foster

change toward a curriculum that is justified in being called “scientist–practitioner,” however, these political obstacles need to be overcome.

Furthermore, in a time of increasing competition for predoctoral internship placements, the trend toward empirically supported treatments and other methods poses an interesting challenge for graduate training programs. Graduate programs may perceive pressure from internship sites to prepare their students with experiences in certain procedures that have questionable empirical support. For example, first-year clinical assessment courses commonly provide training in various assessment procedures with the disclaimer that they are basically invalid but “required for internship.” As a result, procedures that lack an empirical basis continue to be a component of otherwise empirically grounded curricula.

This state of affairs presents a dilemma for scientist–practitioner training programs. On the one hand, they have a vested interest in giving their students that “extra edge” required for obtaining an internship. On the other hand, they must be aware that they are wasting time by teaching students invalid procedures. Regarding the decision of whether certain methods should remain a part of the curriculum, an important question is what is in the best interest of the student, the program, the field of clinical psychology, and even the internship site. Is it really in everyone’s best interest to have students learn ineffective methods (which take away time and resources from learning effective methods), even if that means a certain advantage at *some* (clearly not all) internship sites? Our answer is that, for the most part, the integrity of scientist–practitioner programs, as well as the integrity of a field that likes to call itself “science-based,” are better served by recommending against training in long-standing assessment and intervention methods that lack empirical justification.

The Challenge of Implementing Empirically Supported Procedures

The challenges continue once empirically supported procedures are part of the training curriculum. Most empirically supported intervention procedures derive from studies that use treatment manuals. These manuals are intrinsic to ESTs and are usually based on DSM (*Diagnostic and Statistical Manual*; American Psychiatric Association, 1994) diagnoses. Davison (1998) has pointed out the dangers inherent in the use of such manuals in graduate education, as they discourage learning about functional analysis and other approaches to the idiographic study of the individual client.

Treatment manuals may also constrain clinical innovation. Some provide detailed session-by-session guidelines and even instruct the therapist what to say on a minute-by-minute basis. This “cookbook approach” can be very reassuring for the inexperienced clinician—just follow the manual and

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