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AUTHOR Chambliss, Catherine  
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ABSTRACT

State governments have either licensed Master's level professionals in the social science areas as "professional counselors," or are considering such legislation. If enacted, such licensing reform would enable counselors to provide psychotherapy to their clients on a fee for service basis. Such reforms will dramatically affect the field of psychology, with possibly dire consequences for licensed Ph.D. psychologists. This paper argues that professional training in psychotherapy is important to a therapist much as a liberal arts education is important to the student who wishes to develop critical thinking skills which prepare him or her for a lifetime of learning and service--the values in clinical training may lay more in process than content. Rather than training in narrowly-defined occupational skills, the professional training of therapists has value because it teaches some general lessons in problem-solving, theory application, research design, and how to make use of the ever-burgeoning, and often contradictory, psychological research literature. The paper concludes by discussing several possible responses to the aforementioned challenges to Ph.D.s: (1) the profession may self-correct; (2) diagnosis and testing could be emphasized by Ph.D.s; (3) Ph.D.s could stay more abreast of research; (4) litigation risks may increase for less credentialed therapists; and (5) doctoral level psychologists may be granted prescription privileges. (TS)

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# Challenges Confronting Doctoral Level Psychologists

Catherine Chambliss, Ph.D.

Ursinus College

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## Shifting Licensing Practices Threaten Ph.D.s

In December 1993, New Jersey created a board to develop regulations which will permit licensing of masters level professionals in the social science areas as "professional counselors". These counselors will be able to provide psychotherapy to their clients on a fee for service basis.

As of this date, no professional counselors have been licensed in New Jersey. However, when they start licensing such counselors, it is assumed that managed health care organizations will start contracting with such professionals. Managed care organizations (MCOs) already make extensive use of licensed MSWs, and indirectly use the services of many MA psychologists. Prior to this licensing reform, MCOs have typically worked indirectly with MAs, by contracting with doctoral level providers who refer work to masters level psychologists whom they . pervise. Directly referring to these masters level psychologists would be cost-

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effective for the MCOs, because it would eliminate the psychologist middleman.

In Canada, several provinces already license masters level practitioners. These providers perform most of the functions of their doctoral level counterparts. California currently licenses masters level professionals as marriage counselors. There is conjecture that several other states are considering similar licensing reform. The privatization of professional psychologist licensing in several states may also contribute to this trend of challenging existing stringent licensing practices.

Such reforms will dramatically affect the field of psychology, with possibly dire consequences for licensed Ph.D. psychologists. Numerous clinical and counseling psychology Ph.D.s and Psy.D.s are lamenting the fact that much managed care business is already going to masters level practitioners. They are frustrated by the apparent lack of respect for the advanced skills of doctorate level practitioners.

A current overabundance of doctoral level practitioners, that some attribute to the recent proliferation of Psy.D. programs, has compounded these problems. While some believe this will be self-correcting, as more students steer clear of this professional glut, a dramatic increase in the number of undergraduates majoring in psychology does not augur well. Furthermore, the number of graduate students already in the "pipeline" is at an all time high, outstripping the capacity of internship programs to accomodate their training needs.

## Are Doctoral Psychologists More Valuable?

One hope for professional psychology might be research which supports doctoral providers' claims that they are more qualified than master level psychologists to provide therapy. However, at present, the results are mixed.

Many research studies show no differences between trained and untrained staff in treatment outcome. These arguments are explored in a recent book by Robyn Dawes entitled House of Cards (1994), in which he argues for licensing of master level professionals, given the lack of research support for current practices. Known as a gadfly in A.P.A. circles, he is quite willing to say that the emperor has no clothes.

### Debating the Merits of Doctoral Level Training

The failure to demonstrate that trained therapists help their clients more than untrained therapists does not prove that training confers no advantages (the null hypothesis can not be proven). The studies cited by Dawes (1994) explored the effects of training on the conduct of conversational therapy. For several decades, advanced clinical training in APA approved programs has focused on the refinement of more directive therapy skills (e.g., cognitive-behavioral therapy (Beck, 1978), multimodal therapy (Lazarus, 1989), etc.). The advantages of training may be more evident in cases where treatment is of short duration.

In fact, some studies have already found that clinicians' training and experience make more of a measurable difference in cases of brief therapy (Berman & Norton, 1985). Their metaanalytic investigation of psychotherapy studies found that although there appeared to be no difference between trained and untrained therapists in long-term therapy, such was not the case for short-term work. This finding has significant implications, given that brief therapy is the modal treatment in HMOs.

The Dawes citations also fail to demonstrate that conversational therapy is not valuable. The fact that some untrained providers can make beneficial use of these methods with clients, does not mean the methods are not useful.

Some of Dawes' pronouncements may have been premature and overly simplistic. Although in many cases outcomes may be the same, the time it takes to get there may be different. Despite Dawes' contentions, other research has shown that trained Ph.D. psychologists are more effective at providing brief therapy. They may get results more expediently than masters level psychologists. This converges with the priorities of managed health care organizations.

Other studies have provided evidence to support the contention that therapist experience is generally associated with better outcomes in treatment (Bergin and Lambert, 1978). Here, the overall findings indicate that greater experience also correlates with higher drop out rates. Interestingly, this may be a sign of trained therapists' greater efficiency (Berman &

Norton, 1985). The high "drop out" rate may include many cases where clients received what they wanted (efficient problem reduction) and left. Therapists' ambitions for these clients may have been greater, and consequently the clinicians defined their cases as incomplete treatment.

Some maintain that research which purely looks at therapy outcome is showing no significant difference between professions or levels of training largely because such research, in reducing down to the convenient measurable outcomes, misses the larger issue. Clinical experience suggests that inadequate diagnosis may have distorted some of the comparative outcome studies showing no training effects. There are many reports of clients who have gone for counseling or therapy conducted by therapists with less training, who have been told that their problem was the more extreme of those considered. If this type of diagnostic inflation occurs frequently with masters level counselors, it could confound the outcome research. If masters level providers use less stringent diagnostic criteria, on average their caseloads would carry more serious diagnoses. This could make it appear that these less trained therapists were effective in treating clients with more refractory problems, when in fact they were not working with many of these difficult disorders at all.

There is some evidence to support the idea that client-therapist congruence with regard to therapy goals and expectations (i.e., independent of training level) between patient and clinician are indeed related to positive treatment

outcome. To the extent that advanced training facilitates the practitioner's congruence, it should confer benefits on clinical skills. A good internship program and high quality supervision should achieve some enhancement of therapist congruence. These programs need to measure their impact on therapist congruence, in order to gauge the value they are adding to their trainees.

Researchers have looked at gender, and seen no significant differences in therapy outcome across gender and levels of training (Beutler, Crago and Arizmindi, 1986). Investigations of personality factors have also yielded insignificant results (Sloane, et al, 1975), though clinicians viewed as "healthier" by their patients appear to have more positive results in treatment.

While "competence" has been difficult to assess (because of the difficulty in operationalizing the term), it remains that competence does relate significantly to therapeutic outcome. In fact, Lambert et al (1986) discuss how the competence of the therapist contributes more to patient improvement than the particular treatment modality used.

#### The Amorphous Contributions of Doctoral Clinical Training

Professional training in psychotherapy is important in order to equip a group of future professionals with confidence in these methods, and familiarity with related ethical issues. This may be more important than teaching particular interpersonal communication skills, in part because students are selected on

the basis of already having many of these competencies when they matriculate. The application process to many training programs is extraordinarily competitive (Sayette, Mayne, & Norcross, 1992). Students are selected on the basis of many criteria, including their having demonstrated a special capacity for mature, responsible, intelligent, sensitive interpersonal conduct. Training may refine these competencies, and increase self-awareness, but programs have long recognized their limited ability to create these skills when they are lacking. Evidence of this acknowledged inability of graduate training programs to manufacture these skills is found in the large number of graduate students who are discontinued during their training experience because they are seen as poor future clinicians. Programs don't expect to remedy these deficits. Instead, they are seen as examples of faulty prediction or failures in the admission process to accurately identify the requisite communication and interpersonal skills.

The professional therapist accepts responsibility for conducting the helping process in an ethically accountable way, and this requires preparation. Unlike most citizens who may have the potential to offer helpful, supportive conversational opportunities to those in need, the professional clinician chooses to accept the responsibility to do so largely unsupervised, and to resist the temptation to "pass the buck." In most of the studies Dawes cites, circumstances were often highly artificial, subjects were randomly assigned, and most



importantly, the untrained counselors knew there was a professional "safety net", if issues became too difficult for them to handle comfortably. Perhaps learning how to operate without such a net is what requires specialized advanced clinical educational opportunities.

What defines a professional clinician is in part their willingness to respond in the difficult cases no one else is willing to bother with. Such cases can't always be predicted ahead of time, and labeling them as extraordinary would compound the problems confronting the individual. During an initial encounter, the professional has little idea of what to expect. The client may be perfectly rational, straightforward, and appropriately socialized to respect the rights of others.

Alternatively, none of those characteristics may apply. Training helps the professional contend with the enormous responsibility associated with taking the risk of working in the realm of the unknown, when the human stakes can be very high.

Clinical training develops trust in one's judgments about enormously complex human situations. To be influential in making suggestions about alternative courses of action a person might take in order to try to improve their circumstances, it is vital to appear credible and reasonably confident. Without experience in advising others, it is very difficult to convey these qualities. Our society abounds in psychological myth; part of clinical training involves discarding many popular but unfounded ideas about behavioral causation. Those who are conscientiously

committed to helping others need to sort out the facts from fiction, and to review the extant psychological literature comprehensively, before they will be comfortable in the helping role.

Only by studying the wealth of information we have thusfar accumulated, and learning to appreciate its limits, can the responsible would-be helper be freed from the nagging distraction of thoughts about the possibility that additional background or expertise might improve their ability to respond. This process of training sometimes ends with a greater willingness to use the common sense one possessed all along. This may be part of why there is often little difference between the "common-sensical" guidance offered by college professors commandeered for these studies and their trained clinical counterparts. In many cases, the trained clinician has learned the "best answer" is the one predicated on common sense. However, they have also learned that in some cases, common sense is misleading, and can result in destructive interactions. It may be that most of the time the expertise created by training is not necessary. However, when it matters, it may matter significantly.

Given the dizzying pace of change in health care, professionals must be flexible and adept at accommodating new demands that dictate the way they work. Professional training develops the necessary ability to creatively manipulate treatment parameters in order to provide optimal care midst radically changing circumstances (Austad, et al, 1993). For example,

although the majority of respondents in a survey of HMO providers stated that their graduate school experience had not adequately prepared them for the specific demands of the new managed care environment they encountered as professionals, the majority had obtained the skills necessary to develop the appropriate competencies on the job.

Much as a liberal arts education is often defended as providing an all-important orientation to critical thinking, that forms the basis for lifelong learning and service, in many respects clinical training may be more about process than content. Rather than training in specific narrow occupational skills, the professional training of therapists has value because it teaches some general lessons in problem-solving, theory application, research design, and how to make use of the ever-burgeoning, and often contradictory, psychological research literature, in order to facilitate the lives of others.

### Possible Responses to these Challenges

#### I.

#### The Overabundance of Psychologists is Temporary Excess will Self-Select Out of the Field

Some of the problems identified within the professions may self-correct through a number of means. First, there will probably be many fewer Ph.D. clinicians graduating in the near

future. This will increase the demand for those who have advanced skills. However, if one considers the recent figures showing the overabundance of psychologists-to-be already in the pipeline (APA Monitor, 1995), it may be hard to believe that this in and of itself will offer a sufficient remedy to the problem.

## II.

### Diagnosis & Testing Should be Emphasized by Ph.D.s

Second, an expected re-emphasis of testing and diagnosis in training for Ph.D. psychologists may help differentiate doctoral level psychology practitioners from the other professions. Doctoral psychologists can and should research and define their expertise involving accurate diagnosis. In particular, because they have the training and experience to integrate psychological testing into assessments, using instruments which are reliable & valid for the purpose, they have a wider data set than the clinician who a) relies on patient report only; b) has no other data available, and c) who might only have two years of training in treatment with little, if any, training in differential diagnosis. It would be advantageous for them if psychologists could demonstrate that they are better at accurate diagnosis (and the corollary, that inaccurate diagnosis contributes to the lack of difference across those with different levels of training observed in many studies).

There are many reports of clients who have gone through "counseling" with a masters level provider for one thing or another, without recognition of a clear diagnosis (e.g., the client who has been in/out of counseling for several years for "depression" when, in fact, her "depression" was a result of crippling Generalized Anxiety Disorder). Diagnostic acumen permits selection of a more appropriate treatment modality, which can reduce the length and cost of care.

Managed care demands that providers have sophisticated diagnostic skills, and generally doctoral level providers have a more appropriate background for this than those with masters degrees. Doctoral level practitioners are more likely to have obtained experience with diverse patient populations. Since managed care organizations need to find alternatives to expensive inpatient treatment for severely and persistently mentally ill (SPMI) clients, the doctoral level practitioner with SPMI experience can be quite valuable to managed care companies. Unlike some of their masters level counterparts, whose clinical experience has been limited to the worried well, these providers can perform challenging differential diagnoses, and contribute to efforts to develop community alternatives to hospitalization for the SPMI population (Oxman & Chambliss, 1996).

However, some argue that there is very little "science" in the practice of diagnosing. Since it has been psychiatrists, not psychologists, who came up with a workable diagnostic classification system in widespread use across fields, it may be

difficult for psychologists to claim any special lock or skill in this area. There are many psychiatrists and social workers who can come to more accurate and reliable diagnoses than many psychologists, especially if they have had more experience in settings that require careful diagnosis.

An area in which psychology has been the leader in development and implementation has been testing. While various fields (besides MA psychologist) are getting into this area, the quality of work conducted by non-doctoral level practitioners is clearly open to question. The interpretation of tests by masters level psychologists is often inferior to that of doctoral level professionals (although there are notable exceptions). Most masters level practitioners have a quite limited knowledge of psychometrics.

Unfortunately, already fewer and fewer companies are paying for psychological evaluations (an exception is neuropsychological testing). Furthermore, despite questions about professional competence, social workers and psychiatrists are increasingly using psychological measurements, with the blessings of the testing companies that distribute them.

### III.

#### Ph.D.s Stay More Abreast of Research

Another way in which doctoral training makes a difference is in the ability (and willingness) to read and apply the professional literature. Reading the research literature is a critical component of scholarship and professional activity, and a focus of graduate training. While there may be arguments over specific research designs, findings, philosophies, the fact remains that doctoral level psychologists rely on their communal intellectual development to move them forward as a profession.

Several providers with masters degrees in psychology areas admit that their training did not prepare them to participate fully in the increasingly important professional discussion of the empirical literature. A selection factor may also be operating. Those completing doctoral programs may have greater facility for analyzing the increasingly complex research that dominates our discipline.

Doctoral level clinical psychology programs follow a scientist-practitioner model of professional training. Their graduates are qualified to contribute actively as researchers, whereas MSW's and MD are only "consumers" of science. As practitioners strive to deliver cutting edge care in an increasingly accountable fashion, this dual professional background should become especially valuable. Clinicians who can participate in empirical investigations of strategies for streamlining treatment delivery should have an advantage over those who need to rely on the work of others.

#### IV.

##### Litigation Risks Associated With Use of Unlicensed Providers

Finally, some think that the personal injury attorneys will eventually be influential in reducing the reliance on less trained providers. Some believe these attorneys will begin to sue the HMO's and individual practitioners whenever something goes wrong on the watch of less credentialed therapists, whether they are to blame or not.

#### V.

##### Prescription Privileges

This controversial strategy to enlarge the professional purview of doctoral level psychologists, in order to deal with market competition concerns, may not provide much relief for psychologists who feel their professional domain has grown too crowded. While there are legitimate reasons for arguing that trained psychologists may more effectively medicate than many general practitioners, who have limited familiarity with mental illnesses and the action of psychotropics, prescribing privileges will not offer psychologists a professional panacea.

At a time when medicine itself is relying more and more on nurse practitioners, physician assistants, and pharmacists in the



provision of services, seeking these increasingly ubiquitous privileges may not be an optimal direction for doctoral level psychologists to pursue. Psychologists may gain this right at the same time it starts to lose its market value, because of the proliferation of medical privileging. Furthermore, if they divert many resources in order to secure this prerogative, other fires may go untended.

## References

- Austad, C., Sherman, W., & Holstein, L. (1993).  
Psychotherapists in the HMO HMO Practice, 7 (3), 122-126
- Berman, J.S. & Norton, N.C. (1985) Does professional training  
make a therapist more effective? Psychological Bulletin, 98, 401-  
407
- Dawes, R. (1994), House of Cards, Free Press, New York.
- Levin, B., Glasser, J., Jafee, C. (1988) National trends in  
coverage and utilization of mental health, alcohol, and substance  
abuse services within managed health care systems, American  
Journal of Public Health, 78, 1222-1223
- Oxman, E. & Chambliss, C. (1996) The Mutual Benefits of Trial By  
Fire: Long-term Inpatient Training Sites, paper presented at the  
American Psychological Association Convention, Toronto.
- Peterson, D.R. (1995) The Reflective Educator, American  
Psychologist, 50, 12, 975-983
- Sayette, M., Mayne, T., & Norcross, J. (1992) Insider's guide to  
Graduate Programs in Clinical Psychology, Guilford, New York.