The Narrowing of Theoretical Orientations in Clinical Psychology Doctoral Training

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The focus of this article is the increasingly narrow range of therapeutic orientations represented in clinical psychology graduate training programs, particularly within the most research-oriented programs. Data on the self-reported therapeutic orientations of faculty at “clinical science” Ph.D. programs, Ph.D. programs at comprehensive universities in clinical and in counseling psychology, Psy.D. programs at comprehensive universities, and Ph.D. or Psy.D. programs at freestanding specialized institutions reveal a strong predominance of faculty with cognitive-behavioral orientations at the more science-focused programs, and a narrower range of orientations than in the more practice-focused programs. We discuss the implications of this trend for the future development of clinical psychology and provide suggestions for addressing the attendant concerns.

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The growth of our knowledge is the result of a process closely resembling what Darwin called ‘natural selection’; that is, the natural selection of hypotheses: our knowledge consists, at

every moment, of those hypotheses which have shown their (comparative) fitness by surviving so far in their struggle for existence; a competitive struggle which eliminates those hypotheses which are unfit.

Karl Popper (1979)

The best way to have a good idea is to have a lot of ideas.

Linus Pauling

Doctoral training in clinical psychology is clearly in a state of evolution. The scientist–practitioner (“Boulder”) model that characterized the training landscape since 1949 has been challenged by several strong ideological and sociological forces and developments. Arguments for the value of more practice-focused doctoral training led to the development of Psy.D. programs, beginning in the 1970s. Subsequently, market forces have resulted in the explosive growth of large, practice-focused doctoral training programs at freestanding institutions, dubbed “specialized institutions not offering comprehensive education beyond psychology or counseling” by Sayette, Norcross, and Dimoff (2011, p. 4), and hereafter referred to as “specialized institutions,” as well as a crisis in the oversupply of applicants relative to the availability of doctoral internships (Munsey, 2011; Vasquez, 2011). Controversies about standards for doctoral training programs, especially with regard to the need to teach evidence-based treatments (Bray, 2011; Calhoun, Moras, Pilkonis, & Rehm,

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1998; Davison, 1998; Eby, Chin, Rollock, Schwartz, & Worrell, 2011), continue. And most recently, the assertion by some that current American Psychological Association (APA) accreditation standards and practices are undermining the science of clinical psychology has resulted in the creation of alternative accreditation standards that emphasize research and clinical training focusing on empirically supported treatments and assessment (Baker, McFall, & Shoham, 2009; McFall, 2007). The outcomes of this evolution in training are difficult to predict, and the relative merits of the various training models are a matter of widely diverging opinions and beyond the scope of this article.

However, a recent study of APA-accredited clinical Ph.D. programs (Sayette et al., 2011), including the Academy of Psychological Clinical Science (APCS, 2012)¹ and non-APCS programs in regular (“comprehensive”) university settings and in specialized universities, but excluding Psy.D. and counseling psychology Ph.D. programs, demonstrated a number of significant differences in acceptance rates, numbers of applicants admitted, admissions credentials, extent of financial aid, student demographic characteristics, and program features (e.g., research funding, internship acceptance rates). The study also found stronger faculty allegiance to a cognitive-behavioral orientation in APCS programs (80%), as compared with non-APCS programs (67%) and programs in the specialized institutions (37%), as well as stronger allegiances to psychodynamic and humanistic/existential orientations in non-APCS versus APCS programs.

This article expands and critically discusses the latter finding. We argue that the finding regarding theoretical orientation reflects a feature of the evolving training landscape that is central to the future of clinical psychology but which has received little formal attention, that is, the increasingly restricted range of therapeutic orientations that clinical graduate students are expected to draw upon in their professional work. We contend that an unfortunate effect of some otherwise positive developments in promoting clinical psychology as a science is the danger of a monoculture of ideas about the nature of psychotherapeutic change—specifically, a hegemony of cognitive-behavioral theory and therapy. Furthermore, this effect is moderated by the nature of the doctoral training program. That is, the more

research-based, science-focused programs tend to offer the narrowest range of theoretical orientations, whereas the more practice-focused programs present the widest ones. In this article, we present data suggesting that this divide is evident within doctoral programs at comprehensive universities, especially in clinical psychology (but not counseling psychology) programs. The divide is particularly evident when comparing clinical programs at comprehensive universities versus programs at freestanding professional schools of psychology. Following the presentation of data supporting this assertion, we discuss the dangers of these divides.

First, however, consider the following thought exercise. Imagine that you are the mentor of a talented undergraduate who is beginning the clinical psychology doctoral application process. She has a strong liberal arts preparation, with a range of psychology courses in both clinical and nonclinical areas, and good research experience. She plans a career that includes psychotherapy research and theory development, and she wants solid clinical training as well. She is compiling an initial list of programs and is particularly interested in *family systems theory and therapy*. As her mentor, you consider programs with *core* faculty (those who supervise theses and dissertations, that is, excluding adjuncts, off-site practicum supervisors, faculty in departments of psychiatry that do not offer doctoral degrees) who publish research in addition to providing clinical training. Now, repeat the exercise with *humanistic, experiential or existential theory/therapy*, with *psychodynamic theory/therapy*, and with *interpersonal theory/therapy*. Having done this exercise ourselves and having mentored students like this one, we are aware of the difficulty in coming up with programs to suggest; indeed, these lists are likely to be very short.

The data presented below bear out these personal observations. We undertook a systematic study of theoretical orientations represented in clinical and counseling doctoral training programs of various types, using published sources. The *Insider's Guide to Graduate Programs in Clinical and Counseling Psychology* (Sayette, Mayne, & Norcross, 2010) provided information on self-reported theoretical orientations of program faculty in six categories, that is, Psychodynamic, Behavioral, Family Systems, Cognitive Behavioral, Humanistic/Existential, and Other; the guide allows for faculty to

indicate one or more orientations. The APA's 2010 *Graduate Study in Psychology* (APA, 2010) education/accreditation web site (<http://apa.org/ed/accreditation/programs/index.aspx>) and the list of member programs published by the Academy of Psychological Clinical Science (<http://acadpsychclinicalscience.org/members>) provided designations of various program types. As needed, Internet searches of individual programs were used to confirm their statuses as (a) Ph.D. programs at comprehensive universities, (b) Ph.D. programs at comprehensive universities that are designated as clinical science programs, (c) Psy.D. programs at comprehensive university programs, and (d) Psy.D. or Ph.D. programs at freestanding, "specialized" institutions. We included programs in the 50 U.S. states and Canada. Although the APA is phasing out accreditation of Canadian programs as of 2015, our concern is not with credentialing issues, but rather with training and continued development in psychotherapy theory and research, which has been and no doubt will continue to be significantly influenced by Canadian psychology. For this same reason, we also included counseling psychology, but treated it separately, as virtually all counseling psychology doctoral programs are at comprehensive universities and because there are some historical and current differences between counseling and clinical psychology. Moreover, we excluded the eight APA-accredited "combined" (e.g., school/clinical, school/counseling) programs.

Table 1 presents the mean percentages of faculty in various types of clinical psychology doctoral programs who self-report particular theoretical orientations.² The

comparison is striking. In the clinical science programs, fully 80% of faculty claim a cognitive-behavioral orientation, and 89% claim either a behavioral or cognitive-behavioral orientation, whereas small percentages of faculty claim either a psychodynamic or a humanistic/existential orientation. Fewer than half of the faculty in Psy.D. programs at comprehensive universities and in Psy.D. or Ph.D. programs in freestanding universities claim a CBT orientation, with noticeably higher percentages of faculty (28% and 29%, respectively) claiming a psychodynamic orientation. Interestingly, the least variation across programs was found in the percentages of faculty claiming a family systems orientation, close to 20% of faculty in each type of program.

Table 2 presents the mean percentages of faculty in counseling psychology doctoral programs who self-report particular theoretical orientations. These data reveal a wider range of orientations, with fewer than half claiming a behavioral or cognitive-behavioral orientation and nearly a third claiming a humanistic/existential orientation. Explanations for this variation will be advanced shortly.

Some elaboration and qualifications of these data are in order. First, in the *Insider's Guide*, programs could also designate faculty with "other" orientations. These data were sparse and often unique to individual programs or individual faculty and thus are not included in the table, but rather summarized as follows. Of the 54 clinical science programs, only two cited one or more "other" orientations. These (and the number of programs that cited them) were neuropsychology (1), community (1), interpersonal (1), motivational inter-

Table 1. Therapeutic orientations of faculty in clinical psychology doctoral training programs

Program Type	Psychodynamic (%)	Behavioral (%)	Family Systems (%)	Humanistic/Existential (%)	Cognitive ^a Behavioral (%)
Ph.D. programs designated as "clinical science" ^b programs (<i>n</i> = 54)	7	9	17	4	80
All other Ph.D. programs at comprehensive universities (<i>n</i> = 116)	19	11	20	24	67
Psy.D. programs at comprehensive universities (<i>n</i> = 31)	28	5	16	12	48
Psy.D. and Ph.D. programs at freestanding professional schools (<i>n</i> = 37)	29	6	22	15	32
<i>Ms</i>	21	8	19	14	57

^a Source: Sayette et al. (2010).

^b Source: Academy of Psychological Clinical Science (<http://acadpsychclinicalscience.org/index.php?page=members>).

Table 2. Therapeutic orientations of faculty in counseling psychology doctoral training programs

	Psychodynamic (%)	Behavioral (%)	Family Systems (%)	Humanistic/ Existential (%)	Cognitive ^a Behavioral (%)
Ph.D. programs at comprehensive universities (<i>n</i> = 67)	19	1	18	31	42

^aSource: Sayette et al. (2010).

viewing (1), child (1), and eclectic (1). Of the 116 other clinical Ph.D. programs at comprehensive universities, 15 listed faculty with “other” orientations: health (1), integrative (3), community (1), clinical neuropsychology (3), eclectic (1), interpersonal or interpersonal/ego relations or cognitive/interpersonal (5), developmental psychopathology (1), feminist (2), cognitive (1), narrative/personal construct (1). Of the 31 Psy.D. programs at comprehensive universities, only one listed an “other” orientation: integrative/transrational. Of the 38 programs at freestanding professional schools, four listed “other” orientations: research (1), integrative (2), cultural diversity focus (1). And of the 66 doctoral counseling programs, 13 listed “other” orientations: eclectic (1), integrative (1), interpersonal (7), feminist/multicultural or feminist or multicultural (13), constructivist (2), relational/process (1), narrative (1), developmental systems (2).

Second, the data on orientations in the *Insider's Guide* were only available as percentages. We do not know how many actual *faculty* are represented in these percentages; “20%” of faculty claiming a family systems orientation could refer to one or two individuals in smaller programs, but several individuals in programs with larger faculties. Although the APA *Graduate Study* guide lists numbers of faculty, it was not possible (given changing faculty sizes, variability in the recency of the data in each source) to accurately compare the data in these two sources to derive the raw numbers of faculty. Nevertheless, this issue is of obvious importance, because it speaks to the actual availability of mentors and supervisors representing particular orientations, as well as the viability of training and research from the particular theoretical orientation at any given program.

Adding the percentages for each program, however, provides a rough index of the extent to which faculty at a particular program claim more than one allegiance, that is, eclectic orientations. That is, in programs at

which each faculty member claims a single orientation, the mean percentages for each orientation total to 100%. For programs in which faculty members claim more than one orientation, the percentages total to more than 100%, with higher totals representing more faculty claiming multiple allegiances. The total percentages averaged across the different program types are the following: Ph.D. programs at comprehensive universities, *M* = 129%, Ph.D. programs at comprehensive universities that are designated as clinical science programs, *M* = 107%, Psy.D. programs at comprehensive university programs, *M* = 110%, Psy.D. or Ph.D. programs at the freestanding, “specialized” institutions, *M* = 105%, and counseling psychology doctoral programs, *M* = 114%. Interestingly, the modal and median percentage totals were the same (each 100%) for every program type.

SO WHAT? IMPLICATIONS FOR TRAINING, RESEARCH, THEORY, AND PRACTICE

The data revealed two major divisions: between the types of theoretical orientations in which current students/future clinical psychologists are being trained and between the theoretical orientations predominant in the more research-focused and more practice-focused programs. These divides are potentially dangerous for the field and the future development of psychotherapy theory and research.

It should be noted as well that the data revealed a third divide, between clinical and counseling psychology programs, which is noteworthy in that it provides some context for the current concern. The broader theoretical focus in counseling psychology can be explained by differences in its history and training philosophies. Although counseling psychology training programs have required curricula and training experiences that are similar to those of clinical psychology programs, counseling psychology has different roots in

group career counseling, vocational rehabilitation of WWII veterans (Gelso & Fretz, 1992), and counseling of “normal” individuals with developmental difficulties or life problems (Friedlander, Pieterse, & Lambert, 2012). This history dovetails with the fact that the predominant training model in counseling psychology for the last 45 years has focused on relationship-oriented and microcounseling skills (Egan, 2007; Hill, 2004; Ivey & Ivey, 2007; Ridley, Kelly, & Mollen, 2011). In practicum training, the preferred supervision approach is to foster trainees’ experience with a range of theoretical approaches, always being guided by clients’ individual problems and needs. Most counseling psychology programs do not hire faculty members based on theoretical orientation; rather, the prevailing preference seems to be a faculty that represents a broad range of approaches. Further, reflecting the de-emphasis on the medical model (matching treatment to diagnosis) and the preferred emphasis on relationship skills and common factors, counseling psychology researchers have traditionally focused more on explicating therapeutic change factors than on comparing client outcomes by treatment approach. Indeed, some of the historically most influential lines of psychotherapy process research were conducted by counseling psychologists, for example, Edward Bordin, Charles Gelso, Leslie Greenberg, Adam Horvath, Clara Hill, Laura Rice, and Stanley Strong.

Returning to the two major divides, regarding the first, we would argue that the increasing dominance of CBT, while derived in part from the early body of research (Chambless et al., 1996) examining and supporting its efficacy, is not optimal for the continued development of psychotherapy specifically, and clinical psychology more generally. In particular, we suggest that it is highly limiting to have the field dominated by *any* single theory of change. If CBT were the only effective treatment, this would not be problematic. But converging evidence indicates that CBT is *not* in fact the only effective treatment, as demonstrated by the Dodo verdict; the fact that, typically, only a small percentage of outcome variance is accounted for by treatment approach (Wampold, 2001); the demonstration of therapist effects and especially (as discussed shortly) the *current* research evidence that a number of treatments from other theoretical approaches are also efficacious,

especially for the treatment for depression (APA Task Force on Psychological Interventions’ 2012 list, <http://www.div12.org/PsychologicalTreatments/disorders.html>). We suggest that an impartial reading of the psychotherapy efficacy literature would not inevitably lead to such a narrow focus on a single theoretical orientation. We also suggest that such a narrow focus is very unlikely to encourage and facilitate the research that is sorely needed on other treatment orientations.

The evolution of theory, research, and practice requires a diversity of ideas and perspectives, and, as Pauling noted, “lots” of them. Indeed, our current major theoretical perspectives evolved from a combination of mutually enriching, sometimes competing, perspectives. For CBT, these have included behavioral, psychodynamic, personal construct, social learning, and other perspectives. Messer (2004), in a discussion of “assimilative integration” (i.e., incorporation of techniques from other types of treatment into one’s “home” therapy), cited Keane and Barlow’s (2002) observation that Freud and Janet most influenced the use of exposure and anxiety management—now considered central features of CBT—in the treatment for PTSD. More recently, we have seen the experiential tradition influencing the evolution of CBT in its new emphasis on affective experience, and the meditative tradition helping to shape Dialectical Behavior Therapy (Linehan, 1993) and variations of cognitive-behavioral treatments for generalized anxiety disorder (Roemer, Erisman, & Orsillo, 2008). Additionally, integrative approaches to treating addictions and associated mental health issues, such as motivational interviewing, draw heavily on the client-centered model of therapeutic practice (Angus & Kagan, 2009).

Why is the current dominance of a single theoretical perspective potentially problematic? A generation of students trained to think from only one perspective will become theorists, teachers, researchers, and practitioners whose creativity, intellectual flexibility, and ability to create new treatments for changing times, troubles, and client populations are likely to be diminished. Further, a generation of students trained (implicitly or explicitly) to *trust* in only one perspective will become a generation that is less willing to be open to different ideas and most importantly, less able to meet the emerging mental health needs of the future.

John Stuart Mill, a strong advocate of empirical methods in scientific procedure in the 19th century and a philosophical progenitor of behaviorism, argued that a plurality of views is needed in science (Cohen, 1961). Mill's reasons are as appropriate for training in clinical and counseling psychology as they are for scientific advancement, including the fact that a problematic view may contain some portion of the truth. Moreover, as the prevailing view is never the whole truth, it is only by collision with contrary opinions that the remainder of the truth has a chance of being recognized. One point of view that is wholly true, but not subjected to challenge, will be held as a prejudice rather than derived from a rational basis, and someone holding a particular point of view without considering alternative perspectives will not really understand the meaning of the view he or she holds. Citing Mill and framing this argument in a positive form, Safran and Messer (1997) argued that science and practice flourish in an atmosphere of confronting and discussing difference, noting that "to the extent that confronting alternate therapeutic paradigms and techniques flips us into a 'world-revising mode' ... there is the possibility of its leading to a dialogue which can truly deepen our understanding of the human change process" (1997, p. 142). In the clinical realm as well, there are attendant implications for the ways in which we think philosophically about human nature and human change. It has been argued that exposing psychology students to different theories and visions of reality (Messer & Winokur, 1984) enriches their understanding of clients and ways to treat them, including the possibility of shifting from one perspective to another, thereby encompassing more of the complexity of human behavior (Messer, 2006).

Paradoxically, having both understanding of and competence with two or more treatment orientations may help clinicians use particular treatment protocols with greater fidelity, when that is their goal. There is mounting evidence that the actual therapeutic interventions of clinicians who believe they are following manualized treatment protocols often do not accurately reflect the core treatment principles of that approach (Shoham, 2011). A proposed remedy, training students to understand the difference between going "off-manual" versus practicing "flexibility within

fidelity" (Kendall, Gosch, Furr, & Sood, 2008; Shoham, 2011), requires a deep understanding of what is and what is not a prototypical intervention in the approach at hand. And the latter, we suggest, is facilitated by knowing more than one therapeutic approach well because the distinguishing features between categories of interventions help define them. For example, students who truly understand interpretation but who are following a CBT protocol and attempting to frame cognitive restructuring interventions will be more likely to do so with integrity because they understand the differences between these similar yet distinct constructs at a core level.

Finally, we are concerned that the trend shown in these data is likely to beget more of the same over time. The programs most likely to produce our future academic clinical psychologists—comprehensive Ph.D. programs, perhaps especially those designated as clinical science programs—are the ones with the narrowest range of orientations. Not only will this trend limit the vision and sources of ideas for current students, but also *their* students will be even less likely to have professors and clinical supervisors who represent other orientations, and consequently less likely to have research mentors who are engaged in serious research on psychotherapy from other orientations. We hasten to note that there is no implied criticism here of the core emphasis of clinical science training programs on the need for data regarding the development and validation of treatment approaches. In fact, one of our goals in this commentary is to emphasize and support the assertion that any treatment model worth learning must have compelling data that support its efficacy and effectiveness (and in fact, as noted earlier, a range of treatment approaches do). Rather, the concern is that we may inadvertently be training a generation of students who equate a particular orientation with "good science" and, by implication, other orientations for which compelling data in fact exist, with "bad science" or "no science."

Finally, inasmuch as the growth and development of treatments is facilitated by ongoing exchanges between researchers and practicing clinicians, these divides are dangerous. There is currently considerable distance between the kinds of treatments that practitioners know and use, on the one hand, and the type of

treatment that has come to dominate the research-based treatment development landscape, that is, CBT, on the other. A 2008 APA survey of 5,051 certified Psychology Health Service Providers in the United States revealed the following “primary theoretical orientations,” in descending order: cognitive behavioral (38.9%), psychodynamic/psychoanalytic (15.6%), integrative (14.6%), “other,” which was primarily “eclectic” (6.1%), cognitive (5.1%), humanistic/existential (4.1%), behavioral (2.9%), systems (2.8%), and less than 2% each of biological, developmental, and family (APA, 2008, <http://www.apa.org/workforce/publications/08-hsp/index.aspx>).

Yet, feedback about the clinical realities of implementing treatments as well as (ideally) the input of practitioners into treatment development at early stages is critical. A laudable collaborative project between APA’s Division 12 (Clinical Psychology) and Division 29 (Psychotherapy) solicited clinicians’ feedback about their experiences using various cognitive-behavioral approaches for social phobia, generalized anxiety disorder, and panic (Goldfried, 2010, 2011). This kind of exchange advances intelligent development and refinements of our treatments, but it will be less and less likely to happen among, for example, family therapy, psychodynamic, and experiential researchers and practitioners, given the shrinking numbers of academics asking such questions from these perspectives.

LIMITATIONS AND POSSIBLE COUNTERARGUMENTS

There are some limitations in the data themselves. Only allegiances to the categories of therapeutic orientation included by the *Insider’s Guide* were assessed; also, objections may be raised to the ways in which the approaches are categorized in that book, for example, separating behavioral and cognitive behavioral, and categorizing all psychodynamic approaches as one. Other orientations (e.g., Interpersonal Therapy [IPT], group, eclectic) are missing altogether. An “integrative” choice would have been particularly relevant to the current questions. As it is not included in the *Insider’s Guide*, we have no way of knowing whether faculty “orientation” refers to an orientation with regard to one’s clinical practice (and indeed, how many faculty are engaged in active clinical practice), personal theoretical preference, research domain, or some combination. Further,

the focus of these categories on *treatment orientations* does not capture allegiance to training orientations that focus on aspects of the *therapeutic relationship*, which transcend treatment type, but which are also critically important not only for treatment outcome but also for theory development and research (Norcross, 2011). On the other hand, we note that our sample itself is broader and more representative of psychologists currently engaged in training than other surveys of theoretical orientation, for example, surveys restricted to members of APA’s Division 12 (Clinical Psychology; Norcross, Karpiak, & Santoro, 2005).

The data also cannot reveal how the current state of affairs applies to the actual coursework and practicum training offered within the various types of training programs, nor do the percentages include part-time and adjunct faculty who are hired to teach practical and who are sometimes involved in supervising theses and dissertations at Psy.D. and professional school programs, and thus have some influence on doctoral students’ outlooks. We would argue, however, that the impact of their research mentorship may not be as strong as that of core faculty, who are engaged in research and predominantly shape the intellectual ethos of the program.

In the spirit of the Popper quote, a counterargument to ours may be mounted, namely, that the evolution we described is precisely what is best for the field. The strongest stance would be that it is no longer acceptable to use—or to train students to use—psychological treatments that have not been empirically supported as efficacious for specific psychological disorders in rigorous randomized clinical trial research. On the other end, there are stances that allow for evidence-based practice and training (Levant & Hasan, 2008) that in addition to basing practice on findings from randomized clinical trials, more explicitly recognize the role of clinical expertise, client values and preferences, and other forms of research evidence (Messer, 2004). There are a variety of opinions about the standards by which the acceptability of evidence for a treatment should be decided. We will not hash out the empirically supported treatments debate here as it has been thoroughly discussed in the literature, but we acknowledge that individuals’ and programs’ stances on what constitutes acceptable evidence of treatment effectiveness/efficacy are a key factor in training policies.

We agree that training students in a diversity of poor or wholly untested treatments for the sake of having a variety of options makes no sense and that discredited theories and treatments (cf. Castonguay, 2010; Lilienfeld, 2007), as well as those for which no one seems to be willing or able to mount research programs to evaluate, *should* be “eliminated as unfit.” But we are a long way from the claim that only cognitive-behavioral treatments are empirically supported. As Messer (2004) noted, the literature also reveals a number of what Wampold (2001) defined as “bonafide” therapies: those with a firm theoretical base, an extensive practice history, and a research foundation, even if the treatment does not meet the “empirically supported” criteria as defined by the Task Force (Wampold, Minami, Baskin, & Tierney, 2002; Wampold et al., 1997). Indeed, as noted earlier, the updated APA Division 12 list of research-supported treatments for depression now goes far beyond the narrow range of treatment approaches originally identified and includes 12 different empirically supported treatments for depression that are based on humanistic, psychodynamic, interpersonal, and cognitive therapy models (<http://www.div12.org/PsychologicalTreatments/disorders.html>). Yet, the increasing lack of opportunity for serious graduate study and research on the full range of evidence-based approaches risks creating a situation in which their development will fall increasingly behind, widening these divides.

POSSIBLE SOLUTIONS AND FUTURE DIRECTIONS

First, preparing students to think in an integrative manner may help. It has been demonstrated that the fundamental tenets of one theory also explain client change from other theoretical perspectives. Consider operant conditioning, a hallmark of CBT, which Castonguay, Reid, Halperin, and Goldfried (2003) found to occur in psychodynamic as well as humanistic therapies. Contrariwise, there are features of CBT that are borrowed, knowingly or not, from psychodynamic therapy and that are correlated with change in CBT (Shedler, 2010). The psychotherapy integrationist movement has a long history, which includes Dollard and Miller’s (1950) comparative analysis of behaviorism and psychoanalysis, Frank’s (1961) description of curative factors in healing across cultures, and Lazarus’s (1967) technical eclecticism and multimodal therapy. The

growing trend toward integration came from major theorists who recognized the complexity of the change process and the shortcomings of many unimodal theories. In his 2010 presidential address to the Society for Psychotherapy Research, Castonguay predicted that psychotherapy integration will continue to grow and that the four major systems of therapy will be improved based on research that emphasizes common and contextual factors with diverse client populations. According to him, as we narrow the division between research and clinical practice, integrative psychotherapy is likely to become the gold standard, even if it is not superior to a “pure form” approach. In our data set, there were a few programs that were clearly integrationist evidenced by both a variety of orientations represented and a total number of orientations listed that was well over 100%. Furthermore, a substantial body of efficacy research indicates that successful treatment is accounted for by individual client differences, individual therapist effects, and common factors (expectancy, alliance, etc.) more so than by techniques specific to any particular theoretical orientation (Wampold, 2001). Thus, truly integrative thinking requires training in these research and theoretical bases as well.

Second, the training of top-notch future psychotherapists, psychotherapy theorists, and psychotherapy researchers needs to include an understanding of the latest clinical science in related domains of knowledge such as developmental psychopathology and affective neuroscience. For example, attachment, emotion regulation, autobiographical memory specificity, and perceptual-cognitive biases, among many other topics, are highly relevant to therapy; not only will this understanding enrich the pool of ideas that inform the study of change process mechanisms, but also it will enhance entry-level clinicians’ ability to think broadly and deeply about how and when to use the tools they have. It is erroneous to assume that one orientation is more compatible with basic science than another, the current data notwithstanding. The challenge, of course, is to be true to the intent of training models—to actually expose students to science, teach them how to understand it (and in some cases, how to engage in it), and most importantly, help them to integrate emerging findings in behavioral and clinical science into their practices.

Third, we suggest that monocultures, or near monocultures, tend to reproduce themselves in both subtle and less subtle ways without deliberate attention to intellectual diversity. The chance to talk with colleagues from other theoretical orientations as well as from related disciplines is affected by program infrastructure, from the seemingly mundane (office and laboratory placements, research group assignments, habits of colloquia invitations and attendance) to the less mundane (faculty hiring and graduate student admission practices, tenure and promotion pressures that foster not straying too far from colleagues' beliefs or prevailing department culture). Professional conferences, with a few exceptions (Society for Psychotherapy Integration, Society for Psychotherapy Research), have become increasingly balkanized, top-ranked doctoral programs tend to admit students whose prior training and attitudes about theoretical orientation are fairly set and mirror that of their potential advisor, and grant pressures (which currently favor the predominant treatment approach) help keep students fairly narrowly focused from the time they enter their doctoral programs. Our field needs to think collectively about the implications of such practices. Finally, it bears repeating that advocates of promising treatment approaches that are not widely available for training at present *and* that do still require stronger empirical evidence need to continue their research efforts and to be better supported in doing so. It is interesting and hopeful in this regard that those doctoral programs in comprehensive universities not designated as clinical science programs, and the doctoral programs in counseling psychology, had the highest mean percentages of multiple orientations claimed, 129% and 114%, respectively.

It will be interesting to see whether or not future psychotherapy training continues to be organized around broad umbrella "orientations" or organized more around some other features of treatments. We note, for example, that CBT now represents a highly diverse category of evidence-based protocols (EBPs), which are quite different from each other in underlying theories of change (e.g., exposure in Prolonged Exposure [PE], cognitive restructuring in Cognitive Processing Therapy [CPT]), structures (90-min sessions in PE, 60-min sessions in CPT), and techniques/procedures (in-session, repeated imaginal exposures in PE, use of written narra-

tives in CPT). In fact, the United States Department of Veterans Affairs (VA) purports to provide training and dissemination of specific EBPs for clinicians providing mental health services to veterans (Karlin et al. 2010). The VA's list of these includes the following: CBT for depression, Acceptance and Commitment Therapy (ACT) for depression, IPT for depression, CPT for PTSD, PE for PTSD, Social Skills Training (SST) for severe mental illness, Integrative Behavioral Couple Therapy (IBCT), and Family Psychoeducation.

Should graduate psychotherapy training programs aspire to training models that de-emphasize a focus on particular theoretical orientations and focus more than at present on training in a broad range of evidence-based protocols? On the one hand, it would be a way for students to acquire knowledge earlier in a range of efficacious treatments so that internship and postdoctoral psychotherapy training could be organized around providing more advanced training and supervision. (Currently, many internship and postdoctoral training sites can only provide introductory exposure to evidence-based protocols from approaches other than CBT, due to students' very limited [if any] exposure to these approaches during graduate training.) Further, it might be expected that with experience and supervision, trainees in EBPs naturally evolve toward integration and adaptation of EBPs according to the unique characteristics of individual patients. On the other hand, it could be argued that this kind of training strategy, especially at the graduate (vs. internship or externship) level, would be atheoretical, too narrow and too focused on specific protocols. Rather, students should be trained in the broader theoretical outlooks and non-specific relationship skills, and only then in the specific EBPs, which will lead naturally to an integrative approach informed by a deeper understanding.

In another vein, Follette and Beitz (2003) offer some sensible suggestions for creating a curriculum that teaches students to think in a broad *and* rigorous scientific manner about empirically supported treatments. Specifically, these suggestions call for more attention to *mechanisms* of psychotherapeutic change, which is by definition a multitheoretical or even pantheoretical enterprise, at least. In addition, programs seeking to build strength in training for more than one orientation should "put their best foot forward" by highlighting

the available data, exposing students to the theoretical and empirical base that justifies training in a particular orientation.

In sum, healthy evolution in our field, as in all fields, requires new ideas that derive from varying perspectives. As clinical science progresses, this kind of flexibility, which transcends singular allegiances to one theoretical orientation versus another, will become increasingly important in the development of theory, research, and practice.

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NOTES

1. These are programs that have been determined to meet the criteria outlined by the Academy of Psychological Clinical Science and thus designated by that body as “clinical science” programs. See <http://acadpsychclinicalscience.org/members>.

2. The raw data, including a list of programs in each category, are available upon request.

REFERENCES

- Academy of Psychological Clinical Science. (2012). Member programs. Retrieved June 11, 2011, from <http://acadpsychclinicalscience.org/members>.
- American Psychological Association. (2008). Survey of psychologist-members. Retrieved June 1, 2011, from <http://www.apa.org/workforce/publications/08-hsp/index.aspx>
- American Psychological Association. (2009). *Graduate study in clinical psychology*. Washington, DC: Author.
- American Psychological Association. (2011). Accredited programs in clinical psychology. Retrieved June 1, 2011, from <http://apa.org/ed/accreditation/programs/index.aspx>
- American Psychological Association Task Force on Psychological Interventions. (2012). Division 12 Society of Clinical Psychology. Retrieved June 15, 2012, from <http://www.div12.org/PsychologicalTreatments/disorders.html>
- Angus, L., & Kagan, F. (2009). Therapist empathy and client anxiety reduction in motivational interviewing: “She carries with me, the experience.” *Journal of Clinical Psychology: In Session*, 65, 1156–1167.
- Baker, T. D., McFall, R. M., & Shoham, V. (2009). Current status and future prospects of clinical psychology: Toward a scientifically principled approach to mental and behavioral health care. *Psychological Science in the Public Interest*, 9, 67–103.
- Bray, J. H. (2011). Training for the future of clinical psychology practice. *Training and Education in Professional Psychology*, 5, 69–72.
- Calhoun, K. S., Moras, K., Pilkonis, P., & Rehm, L. P. (1998). Empirically supported treatments: Implications for training. *Journal of Consulting and Clinical Psychology*, 66, 151–162.
- Castonguay, L. G. (2010). *A promising dawn: Integrative connections in psychotherapy*. Presidential address, annual conference of the Society for Psychotherapy Research, Monterey, CA.
- Castonguay, L. G., Reid, J. J., Halperin, G. S., & Goldfried, M. R. (2003). Psychotherapy integration. In G. Stricker & T. A. Widiger (Eds.), *Comprehensive handbook of psychology, Vol. 8: Clinical Psychology* (pp. 327–345). New York: Wiley.
- Chambless, D. L., Sanderson, W. C., Shoham, V., Bennett Johnson, S., Pope, K. S., Crits-Christoph, P., et al. (1996). An update on empirically validated therapies. *The Clinical Psychologist*, 49, 5–18.
- Cohen, M. (Ed.). (1961). *The philosophy of John Stuart Mill*. New York: Modern Library.
- Davison, G. C. (1998). Being bolder with the Boulder model: The challenge of education and training in empirically supported treatments. *Journal of Consulting and Clinical Psychology*, 66, 163–167.
- Dollard, J., & Miller, N. E. (1950). *Personality and psychotherapy*. New York: McGraw-Hill.
- Eby, M. D., Chin, J. L., Rollock, D., Schwartz, J. P., & Worrell, F. C. (2011). Professional psychology training in the era of a thousand flowers: Dilemmas and challenges for the future. *Training and Education in Professional Psychology*, 5, 57–68.
- Egan, G. (2007). *The skilled helper: A problem-management and opportunity-development approach to helping* (8th ed.). Belmont, CA: Brooks/Cole.
- Follette, W. C., & Beitz, K. (2003). Adding a more rigorous scientific agenda to the empirically supported treatment movement. *Behavior Modification*, 27, 369–386.
- Frank, J. (1961). *Persuasion and healing*. Baltimore: Johns Hopkins University Press.
- Friedlander, M. L., Pieterse, A. L., & Lambert, J. E. (2012). The evolution of theory in counseling psychology. In N. Fouad, L. Subich, & J. Carter (Eds.), *APA handbook of counseling psychology* (pp. 31–58). Washington, DC: American Psychological Association.

- Gelso, C. J., & Fretz, B. (1992). *Counseling psychology*. New York: Harcourt Brace Jovanovich.
- Goldfried, M. R. (2010). Clinicians' experiences in using an empirically supported treatment (EST) for panic disorder: Results of a survey. Retrieved June 15, 2012, from <http://www.div12.org>
- Goldfried, M. R. (2011). Generating research questions from clinical experience: Therapists' experiences using CBT for Panic Disorder. *The Behavior Therapist*, 34, 57–62.
- Hill, C. E. (2004). *Helping skills: Facilitating exploration, insight, and action* (2nd ed.). Washington, DC: American Psychological Association.
- Ivey, A. E., & Ivey, M. B. (2007). *Intentional interviewing and counseling: Facilitating client development in a multicultural society* (6th ed.). Pacific Grove, CA: Brooks/Cole.
- Karlin, B. E., Ruzek, J. I., Chard, K. M., Eftekhari, A., Monson, C. M., Hembree, E. A., et al. (2010). Dissemination of evidence-based psychological treatments for posttraumatic stress disorder in the Veterans Health Administration. *Journal of Traumatic Stress*, 23, 663–673.
- Keane, T. M., & Barlow, D. H. (2002). Posttraumatic stress disorder. In D. H. Barlow (Ed.), *Anxiety and its disorders* (2nd ed., pp. 418–453). New York: Guilford.
- Kendall, P. C., Gosch, E., Furr, J. M., & Sood, E. (2008). Flexibility within fidelity. *Journal of the American Academy of Child and Adolescent Psychiatry*, 47, 987–993.
- Lazarus, A. A. (1967). In support of technical eclecticism. *Psychological Reports*, 21, 415–416.
- Levant, R. F., & Hasan, N. T. (2008). Evidence-based practice in psychology. *Professional Psychology: Research and Practice*, 39, 658–662.
- Lilienfeld, S. (2007). Psychological treatments that cause harm. *Perspectives on Psychological Science*, 2, 53–69.
- Linehan, M. M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford.
- McFall, R. M. (2007). On psychological clinical science. In T. A. Treat, R. R. Bootzin, & T. B. Baker (Eds.), *Psychological clinical science: Papers in honor of Richard M. McFall* (pp. 363–396). New York: Psychology Press.
- Messer, S. B. (2004). Evidence-based practice: Beyond empirically supported treatments. *Professional Psychology: Research and Practice*, 35, 580–588.
- Messer, S. B. (2006). Psychotherapy integration based on contrasting visions of reality. In G. Stricker, & J. Gold (Eds.), *Casebook of psychotherapy integration* (pp. 281–291). Washington, DC: American Psychological Association Press.
- Messer, S. B., & Winokur, M. (1984). Ways of knowing and visions of reality in psychoanalytic therapy and behavior therapy. In H. Arkowitz, & S. B. Messer (Eds.), *Psychoanalytic therapy and behavior therapy: Is integration possible?* (pp. 63–100). New York: Plenum.
- Munsey, C. (2011). The internship match crisis continues. *Monitor on Psychology*, 42(4), 12–13.
- Norcross, J. C. (Ed.). (2011). *Psychotherapy relationships that work: Evidence-based practice* (2nd ed.). New York: Oxford University Press.
- Norcross, J. C., Karpiak, C. P., & Santoro, S. O. (2005). Clinical psychologists across the years: The Division of Clinical Psychology from 1960 to 2003. *Journal of Clinical Psychology*, 61, 1467–1483.
- Ridley, C. R., Kelly, S. M., & Mollen, D. (2011). Beyond microskills: Toward a model of counseling competence. *The Counseling Psychologist*, 39, 825–864.
- Roemer, L., Erisman, S. M., & Orsillo, S. M. (2008). Mindfulness and acceptance-based treatments for anxiety disorders. In M. M. Antony, & M. B. Stein (Eds.), *Handbook of anxiety and the anxiety disorders* (pp. 476–487). New York: Oxford University Press.
- Safran, J., & Messer, S. B. (1997). Psychotherapy integration: A postmodern critique. *Clinical Psychology: Science and Practice*, 4, 140–152.
- Sayette, M. A., Mayne, T. J., & Norcross, J. C. (2010). *Insider's Guide to Graduate Programs in Clinical and Counseling Psychology*. New York: Guilford.
- Sayette, M. A., Norcross, J. C., & Dimoff, J. D. (2011). The heterogeneity of clinical psychology Ph.D. programs and the distinctiveness of APCS programs. *Clinical Psychology: Science and Practice*, 18, 4–11.
- Shedler, J. (2010). The efficacy of psychodynamic psychotherapy. *American Psychologist*, 65, 98–109.
- Shoham, V. (2011). *Treatment fidelity: The elusive independent variable*. Paper presented at the North American Society for Psychotherapy Research conference, Banff, Alberta.
- Vasquez, M. J. T. (2011). The internship crisis: Strategies and solutions. *Monitor on Psychology*, 42(4), 5.
- Wampold, B. E. (2001). *The great psychotherapy debate*. New York: Lawrence Erlbaum.
- Wampold, B. E., Minami, T., Baskin, T. W., & Tierney, S. C. (2002). A meta-(re) analysis of the effects of cognitive therapy versus 'other therapies' for depression. *Journal of Affective Disorders*, 68, 159–165.
- Wampold, B. E., Mondin, G. W., Moody, M., Stich, F., Benson, K., & Ahn, H. (1997). A meta-analysis of outcome studies comparing bona fide psychotherapies: Empirically, 'all must have prizes'. *Psychological Bulletin*, 122, 203–215.

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