CHAPTER 39

EDUCATION AT THE INTERFACE

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Most of the chapters in this volume attend to the ever-growing content of health research and health service delivery in the interface between social and clinical psychology. The breadth and depth of this content are testimony to Harvey and Weary's (1979) vision, because they called for not just a rapprochement but an active, integrated collaboration of the social and clinical areas in psychology. The sweep of the topics—from self processes and individual differences, to interpersonal processes, to diagnosis and treatment—indicates just how much of psychology can be included within the health area of the interface.

It appears to us that if these multiple topics compose the “what” of health research and training at the interface, then several of the chapters in the current section comprise the “where”; for instance, where the current emphases will go in terms of methodological and theoretical issues, and where our future focus might be (e.g., prevention). The present chapter offers a modest “how” that must necessarily be added to any consideration of what or where—the “how” of training and education at the interface.

Most of the past attention to interface work has assumed the existence of social and clinical psychologists who could profit from more frequent and wide-ranging collaboration in research and practice. Although this volume attests to the validity of this basic assumption, the achievement of maximal productivity in interface efforts (with health representing only one such effort) will necessitate careful and purposive efforts in education of the coming generations of psychologists.

In dealing with the “what,” “where,” and “how” of the interface, it is important not to forget the “who.” In our view, any individual who is involved in either research or practice with explicit attention paid to both clinical and social psychology may be considered as operating within the interface. Thus, traditional social psychologists who want to study social influence processes in therapy settings are operating within the interface. And traditionally trained clinicians who conceptualize therapy as “attitude change” are also operating within the interface. We will not argue in this chapter that working within the interface requires training in a specific type of education/training
model. Rather, we observe that if we wish to foster increased growth of the interface area, we may make more rapid gains to the extent that our training is intentional.

Such education can follow different models, and several of these models are presented in this chapter. The first two sections emphasize the past decade’s development of the interface area and the somewhat parallel development of health psychology and behavioral medicine. The third section focuses on the intersection of these two forces as we discuss health within the social and clinical interface. The fourth section reviews some education/training models already in place and also describes some of the factors promoting, and mitigating against, true interface education. We conclude with a proposal for how education at the interface may offer one prototype for future educative efforts in the multifaceted and currently fragmented discipline of psychology.

It is important to state at the outset that we do not propose that the interface between social and clinical psychology and health psychology are one and the same. Rather, we view health psychology as one forum in which the interface issues can be usefully examined. All interface issues are not health psychology issues, but many of the content and process issues (e.g., what would be included in training, who should provide the training) that have occurred in the health psychology arena are directly applicable to interface issues in other arenas (e.g., psychopathology, relationship research and therapy). Thus, whereas complete overlap between health and the interface is not implied, our thesis is that a very close relationship exists.

THE SOCIAL-CLINICAL INTERFACE

The social-clinical interface is a complex area. Any serious consideration of education and training of graduate students for interface activities requires some background understanding of what we mean by the interface, of the span of concerns encompassed by the interface, and of the issues involved in interface training activities. These topics will be considered in turn.

Basis of the Interface

Social and clinical psychology have always had a loose association with each other, although as the professional roles of the two disciplines have developed the activities shared have become increasingly infrequent. During previous years, interface activity was discussed primarily in terms of whether the two disciplines could contribute jointly to the practice of psychotherapy. Weary (1987) argued that the focus on psychotherapy is shifting toward an increased concern with the role of social-psychological factors in the development and maintenance of dysfunctional behaviors. Thus, the area of mutual concern may be in a point of transition. Be that as it may, it is relatively clear that the initial focus was on psychotherapy, a central area of endeavor for clinical psychology.

One of us (C. Hendrick, 1983) made a strong polemical argument that social psychology should have the same right to practice psychotherapy as clinical psychology. This argument was based on the assumption that psychotherapy is first and foremost a species of human interaction. It is true that psychotherapy evolved to treat mental illness, which was conceived as a disease entity within the organism that must be exercised. Medicine developed primarily as a discipline for the cure of disease. As psychiatry emerged it was natural to consider mental illness as a disease that should be treated and cured by medicine. But increasingly over the years, psychiatry and clinical psychology have come to view mental illness as a disturbance in interpersonal relations. We do not argue, of course, that it is only that, but simply that one primary construal of mental illness has come to be a notion of disturbed interpersonal interactions. C. Hendrick (1983) argued that any human interaction involves three generic classes of behavior: social cognition about the interaction, emotionality as a tenor and tone of the interaction, and a variety of interpersonal processes, including communication, persuasion, exchange, conformity, and so forth. These are the concepts that are the wool and warp of social psychology as a discipline. Further, they are the sorts of conceptions with which Strong (1978) has made such a compelling case over the years for the incorporation of social-psychological knowledge into a basic paradigm for effective psychotherapy. It was on this basis that C. Hendrick (1983) argued that a clinical social-psychology has a right to exist. He implied that social psychology should be the central discipline in psychotherapy because its concepts provide the underlying ideological structure on which current psychotherapy is practiced, notwithstanding the many problems of translating social psychological concepts into specific theories of psychotherapy.
This polemic in favor of social psychology inspired a response (S. S. Hendrick, 1983) that argued for an ecumenical social, counseling, and "x, y, z" psychology. The point was made that all the basic disciplines in psychology have a great deal to contribute to psychotherapy, as well as to other emerging areas, such as health psychology. The particular point that "social psychology should have the same right to practice psychotherapy as clinical psychology" is clearly a controversial one. Social psychology is the discipline that focuses on interpersonal processes, but it concentrates primarily on basic research rather than application. If someone trained in social psychology relied on this view to treat people with psychological problems, would not that person be engaged in clinical psychology? Not unless one assumes that only clinical psychologists can deal with psychological problems. However, this issue raises controversial questions about whether extensive therapy training, as well as professional licensing, are necessary for the therapeutic enterprise. Although these authors are less troubled than many about the concept of social psychologists engaging in psychotherapeutic practice, our purpose in this chapter is not to define "who can do what," and thus perhaps narrow the interface, but rather to paint the interface with as broad a brush stroke as possible.

Broadening the Interface

During the past few years, the concept of an interface has been generalized to include counseling as well as clinical and social psychology. A special issue of the Journal of Social and Clinical Psychology (C. Hendrick, 1987) dealt with a wide variety of issues involved in this triadic interface, including training issues. Because of its focus on healthy functioning in everyday environments, counseling psychology was recognized as having a substantial contribution to make to the interface. The set of articles dealt with a wide variety of possibilities and problems concerned with the interface of the three disciplines. A large number of positive suggestions were made, but there was also considerable pessimism. For example, Strong (1987), a substantial contributor in previous years, did a serious appraisal as to whether a successful integration is possible. He noted that not a single innovation to therapy had resulted from the application of social psychology to therapy in the previous 20 years. Despite his pessimistic appraisal of the fruits of collaboration between clinical and social psychology, he concluded that because of changes in social psychology in recent years there was still some hope for the future.

In a brief commentary article on the previous articles in the special issue, Sarason (1987) showed some pessimism, using the metaphor that although psychology is a vast house of many mansions, few would call it a happy home. Further, he feared that the request for interface activities is more of a plea than a real trend. In part, the conservative nature of training programs serves as a barrier to the integrative tendency. He did, however, see some hope in the fact of the existence of a special issue as a sign that at least some number of psychologists still want the house of psychology to become a home.

The range of attitudes expressed in this series of articles, from pessimistic to optimistic, indicates once again the importance of human interest and commitment in the achievement of innovation. A full integration of clinical, counseling, and social psychology to create a true interface is as simple as a great many people willing and wanting it to be so. However, to the extent that there are reservations, turf issues, suspicions of people in other disciplines, and so forth, such an interface probably cannot occur.

Leary (1987) contributed a valuable conceptual perspective on the interface, taking an approach somewhat different than any previously taken by writers in the area. Leary distinguished among social-dysgenic, social-diagnostic, and social-therapeutic psychology in describing in detail the conceptual delineation of each area. Social-dysgenic psychology is concerned with the understanding of interpersonal processes involved in problem behaviors. In previous years, this approach was relatively narrow and was the province of psychopathologists, particularly in terms of the search for classificatory entities within the individual psyche. During the recent past a wide variety of problem processes have been recognized as suitable for consideration by the mental health professions, including such things as loneliness, shyness, depression, insomnia, spouse abuse, and the like. It is apparent that this list of topics overlaps considerably with interests that have been pursued by social psychologists as well as clinicians. This broader approach to dysfunctional behavior provides, of course, a ready meeting ground for the three disciplines currently under discussion.
Social-diagnostic psychology is Leary's term for the identification and classification of interpersonal problems. He makes the valuable point that the diagnosis of such problems always involves social inference. Further, such inferential processes appear to be on a continuum between the lay inference processes of everyday life and the formal inference process of the clinician in the act of diagnosis. It is an easy step to note the extensive research and literature within social psychology that deal with person perception, attribution, judgmental biases, and the like. It would be highly desirable to begin to integrate those literatures and develop them in such a way that they can apply formally to the diagnostic situations dealt with by the clinician.

Finally, social-therapeutic psychology involves the treatment of dysfunctional behavior, which may be subdivided into (a) the particular set of problems that brought a client to therapy in the first place and (b) the role of interpersonal factors in the ongoing process of counseling and psychotherapy. These three facets of dysfunctionality, diagnosis, and treatment form an interdependent triad that has substantial relevance to all three disciplines of social, clinical, and counseling psychology. Further, as Leary developed these conceptions, it is clear that all three disciplines are intimately involved conceptually, and by inference ought to be involved in varying proportions practically, with clinicians receiving better training in social psychology and social psychologists increasingly turning their attention to studying clinical problems.

Training Considerations

At this point in our history, training considerations for the interface are as varied as the conceptions of what the interface substantively involves. No more than a few examples may be given at this point. Strickland and Halgin (1987) advocated a human services psychology that would include a merger of counseling and clinical psychology, but expand their doctoral training to include social and developmental psychology, thereby creating a kind of "super" discipline that follows the Boulder model of training. Winer (1987) took a strong exception to this model of graduate training, in part because of the probability that in the merger of clinical and counseling, counseling would cease to exist as a viable discipline.

As clinical psychologists have become more aware of the cultural and social factors that impinge on and disturb behavior (Weary, 1987), there has been a reduced emphasis on psychotherapy per se and an attempt to broaden the spectrum of problem behaviors dealt with by professional psychologists. This broadening of perspective of course includes much of the domain of research interests of social psychologists. Such liberation of conceptual boundaries makes possible the joint training, even if with different emphases, of social, clinical, and counseling psychologists. A common curriculum focusing on dysfunctional behavior and the role of social factors in pathology is highly viable, although, as Weary noted, there are substantial professional barriers against the integration of social and clinical psychology.

The approach described by Leary (1987) also has many joint training possibilities. Leary made the same observation that knowledge of dysfunctional behavior and its diagnosis does not prepare one for the practical considerations of therapy. Further, it works both ways. Many psychotherapists are very poorly trained in the social bases of dysfunctional behavior, in the same way that social psychologists are ordinarily totally untrained in therapeutic activities to ameliorate such dysfunctional behavior. In an ideal curriculum, social psychology would have much to offer in the training of counseling and clinical psychologists, and those two disciplines in turn would have much to offer to the enrichment of the training of social psychologists. Exact professional specialization might differ, but all three disciplines could emerge from a common but variegated core of training activities, to the mutual benefit of all three disciplines.

Statements concerning what might be feasible (and even desirable) for interface training appear inherently reasonable, and we believe that the area of health psychology/behavioral medicine offers a useful prototype for future activity in the interface.

DEVELOPMENT OF HEALTH PSYCHOLOGY/BEHAVIORAL MEDICINE

The field of health psychology has blossomed, particularly over the past decade. Behavioral medicine also has thrived. There is some apparent confusion about the relation between health psychology and behavioral medicine, although we believe
that the definitions accorded each in the literature fairly clearly delineate the similarities and differences between the two. Health psychology has been defined as "... a generic field of psychology, with its own body of theory and knowledge, which is differentiated from other fields in psychology" (Stone, 1983). Behavioral medicine appears to cast its net somewhat more widely as "... the interdisciplinary field concerned with the development and integration of behavioral and biomedical science knowledge and techniques relevant to health and illness" (Schwartz & Weiss, 1978). For our purposes, the areas of health psychology and behavioral medicine will be considered as two separate but overlapping entities, with health psychology functioning as one of the several components of behavioral medicine (by definition, an interdisciplinary field).

**Beyond Definitions**

Definitions are just a beginning, though in the case of the definition of health psychology offered above, it marked a process well past its beginning. The National Working Conference on Education and Training in Health Psychology, which met in the spring of 1983 and offered the definition of health psychology noted above, was a formal recognition that health psychology was alive and well and growing at a rapid rate, albeit without benefit of definitions, educational curricula, specified training experiences, and mandated licensing and credentialing. The conference did not initiate health psychology, but rather legitimized it. The (carefully selected) conference participants intended to address both the reality of the existing field of health psychology and to set in place the mechanisms with which to shape its future (similar to the contributors to this volume).

Participants in the conference came from different areas of psychology (e.g., experimental, social, physiological, and clinical) and from various work settings (e.g., universities, professional schools, medical schools, hospitals, rehabilitation settings, and governmental agencies). The diversity of the participants was matched only by the diversity of topics focused on by the task groups. These reports included

- Health policy
- Industrial/organizational settings
- Accreditation
- Credentialing
- Ethical concerns
- Legal issues
- Women and ethnic minorities
- Life-cycle health psychology
- Training venues
- Relationship of health psychology to other areas of psychology and other disciplines and professions

Out of this diversity, however, evolved considerable consensus concerning an appropriate future for health psychology, such as endorsement of the scientist-practitioner model, the value of generic psychological training for health psychologists, need for interdisciplinary education and training, special attention to legal and ethical problems, and so on. Although the interrelationships between mental and physical health were duly noted, and knowledge of aspects of clinical psychology was deemed important for health psychologists in both service delivery and research positions, it was agreed that health psychology was greater than the sum of any of its psychological parts (including clinical) and "... should become an independent specialty" (Stone, 1983).

This movement toward recognition of health psychology as a separate entity appeared congruent with the fact that those psychologists who "... are making the most visible contributions to health psychology ... have come to health psychology via training and backgrounds of experience in every major specialty area of psychology" (Matarazzo, 1983, p. 87). The conference participants also acknowledged the reality that health psychology is important enough and cohesive enough to qualify as a specialty area.

Issues about the specific academic and professional preparation of health psychologists center largely, though not wholly, on scientist-practitioner differences and predoctoral versus postdoctoral specialization. In regard to the former issue, the National Working Conference elected to endorse overlapping scientist and practitioner training paths. In regard to the latter issues, health psychology appears to have a twofold emphasis, with predoctoral health psychology training encompassing generic psychology work as well as a health "track" and health-related practical training, and postdoctoral training encompassing a 2-year specialized training experience (Matarazzo,
1983; Stone, 1983). More recently, Sheridan, Mat- 
arazzo, Ball, Perry, Weiss, & Belar (1988) outlined a model for postdoctoral health psychology training and education that attempts to delineate necessary previous preparation of postdoctoral candidates, general structure of postdoctoral experiences, and techniques and skills to be learned during the postdoctoral years.

It is certainly the case that disciplines other than health psychology—notably clinical psychology and counseling psychology—also have defined their spheres of activity and training models through conferences similar to the National Working Conference on Education and Training in Health Psychology. However, it seems to us that the breadth of topics considered and, even more important, the breadth of disciplines and work settings represented make this conference directly relevant to issues of the interface.

**Choice Points**

Although health psychology is still expanding and does not appear to have yet reified either its entrance requirements or its training approaches, to the extent that it becomes the “property” of any one area of psychology or endorses any narrow view of appropriate education and training, it is likely that the yeasty new specialty will lose some of its vitality. Some mixing of genes ensures a species’ survival; too much inbreeding ensures its eventual demise.

In a recent article, Taylor (1987) wrote on the present progress and future prospects of health psychology. While noting the major achievements of the area (e.g., “documenting the importance of quality of life, identifying the psychological impact of treatment intervention for chronic disorders, and inducing medical care-givers to consider these factors . . .” [p. 74]), Taylor also outlined the need to document treatment effectiveness, demonstrate cost-effectiveness, and deal with logistical issues such as publication outlets for health psychology materials.

Particularly compelling is Taylor’s stance that “. . . the entry-level credential (in health psychology) can be pre-doctoral training . . .” (p. 81). Noting that any requirement of 2 years of post-doctoral training for an entry-level credential may drive the best and brightest young scholars to other areas within and without psychology, she also pointed out a reality that those professionals who are obsessed with licensing and credentialing appear to have overlooked:

There is also a certain irony to the extended and complex curriculum that many in health psychology are outlining for future students, and it is the fact that none of the present ranks in the field went through anything like it. Most of us who are now in health psychology came to it from other disciplines in psychology. When we converted to health psychology, we educated ourselves through whatever haphazard and piece-meal methods were available to us, and if our track record to date is any indication, we have done a fine job of it. Of course, the field is now in a position to offer much better courses and training in research and methods directly relevant to health psychology. But in addition, students deserve some credit for being entrepreneurial about their skills, and we must assume that they will acquire some of the skills they need on their own. (Taylor, 1987, p. 82)

In line with Taylor’s emphasis on openness and flexibility in health psychology is a training component recently discussed by Bresler (1988) that offers both theory and practice in community health promotion within a more traditional clinical psychology curriculum. The training emphasis includes a seminar, student involvement as a member of a risk-factor modification group, and various campus and community intervention projects, including health-promotion activities in a church, and a health-promotion package offered in connection with a local insurance group to 1,100 of its clients. Although Bresler acknowledged the difficulties of integrating additional work in health promotion/health psychology into an already demanding clinical training curriculum, the rewards appear to more than balance out the costs. Being on the cutting edge of a rapidly growing area engenders enthusiasm in students and faculty alike.

Our brief look at health psychology has allowed us to examine the professional questions that confront a new and rapidly growing discipline. The diverse perspectives on education and training in health psychology (e.g., predoctoral vs. postdoctoral training), and the probable evolution of that discipline have implications for the interface of social and clinical psychology and its future development.

**HEALTH IN THE INTERFACE**

Although we noted earlier that health psychology and the interface are not one and the same, we view health psychology as a “model” for the interface, in terms of the former’s growth, boundary definitions, and training issues. In addition, the
topic of "health" can itself be considered within the domain of the social-clinical interface, as it is in the current volume. This placement is exceedingly appropriate, judging by the breadth of the chapters included. Both the range of contributions and the range of contributors testify that health is a great showcase for the talents of the interface. Why is this the case?

A preliminary attempt to answer this question is shown by the model in Figure 39.1. Figure 39.1, adapted from an earlier article (Hendrick & Hendrick, 1984), shows in some detail the vast array of concepts pertaining to health and disease. In the following discussion, we will borrow liberally from that article.

Although psychological concepts can be readily and usefully applied to health behavior and disease states (attribution of cause is one example), such concepts only get at part of the health-disease gestalt. Other, more behavioral and environmental variables related to health and disease (e.g., housing quality, exercise, air and water pollution) might be described as life-style/environmental concepts. Still other concepts, such as ethnicity, socioeconomic status, and the like, might be labeled sociological concepts. Sociological concepts are related to both psychological and environmental factors; however, they are qualitatively different. For example, exercise, in some form, occurs within every social stratum. For the poor migrant laborer, it may occur in the natural course of trying to eke out a living. For the upper middle-class person, however, specific kinds of exercise to attain specific kinds of physiological ends may be carefully planned. Intentional exercise may produce somewhat different results than does naturally occurring exercise.

Thus, the three distinct but related classes of concepts termed psychological, life-style, and sociological bear on the social bases of illness and health. These three systems of concepts may be thought of as three large sets of independent variables, in turn impinging on two sets of dependent variables—illness behavior and health behavior.

If research and intervention efforts are to be effectively directed toward prediction and eventual control among these five interconnected sets of variables, then those professionals involved in such efforts either need tremendous breadth of knowledge or they need to participate in collaborative research.

The latter alternative appears to be the more pragmatic one, and thus there is a seemingly perfect fit of health into the interface area. In their attempt to fit psychobiology within the interface, Spring and her colleagues (Spring, Chiodo, & Bowen, 1987) reprise some of the research on stress, linking early work by social psychologists on crowding, to psychobiological studies on control and cancer, to social-clinical work on stress, competition, and aggression, and to personality psychology theorizing on the "hardy personality" as a healthy response to stress. As these authors wisely noted, one of the reasons for the fecundity of health psychology has been the fact that little of its time (at least up to this point) has been spent in disciplinary turf issues. Although it is possible that current trends to license and credential those who are to be involved in patient-related aspects of health psychology service delivery will needlessly define boundaries of those who "can" and those who "cannot," such a direction appears to us less promising than a yeasty eclecticism.

This eclecticism welcomes the separate but highly congenial contributions of the social psychologist, the clinical psychologist, and the counseling psychologist. The social psychologist brings with him or her a tradition of empiricism as a major approach to finding out answers to individual and group questions. Theoretical curiosity, followed by systematic exploration, are essential to solving some of the highly complex issues related to health and disease. This research tradition has included studies of specific disease states, such as cancer, coronary-prone behavior, and smoking, as well as research concerning the health-care delivery system (e.g., interpersonal interaction among health-care professionals, physician-patient communication).

Clinical psychology brings to health research a respected tradition of concern with the organism gone awry; a push to understand the etiology of physical and mental disease states, the course of such disease states, and various approaches to treatment; and, perhaps, ultimate cure of these disease states. The involvement in health within the interface is quite natural for clinical psychology, as indicated by the significant interface contributions made by clinical psychologists (e.g., Brehm, 1976; Weary & Mirels, 1982).

The historical roots and contemporary foci of counseling psychology as well as the natural bridges between counseling and social psychology have been detailed elsewhere (S. S. Hendrick, 1987). Most relevant to the discussion of health, however, is counseling's long-term involvement
with rehabilitation psychology and career/vocational psychology, and its reliance on short- and intermediate-term therapeutic approaches (Tippton, 1983). Although a disease-focused, remediative approach to illness is entirely defensible, so also is a wellness-focused, preventive approach. It is no accident that the developing area of psychology on which we have concentrated so much attention is called health psychology. There is a historical tendency in psychology to focus on pathology (physiological, cognitive, emotional); however, there also has been an emphasis on articulating processes of normal human development, and counseling psychology has nearly always worked within the latter framework. Thus, counseling is in a rather special position in respect to health within the interface. It is oriented to deal fully with both the personal and professional disruptions evoked by acute and chronic illnesses, as well as to play a prominent role in prevention. This, indeed, is the perspective that really ought to be driving the entire health psychology "machine."

Although we have directed our comments to social, clinical, and counseling psychology, it is apparent to us that "the challenges of health psychology are such that nearly all branches of psychology must contribute to problem definition and solution if more effective prevention and remediation strategies are to be employed" (Hendrick & Hendrick, 1984, p. 191). And if psychology is to contribute in a wide-ranging fashion to problem definition and solution, then it must contribute even more widely to the education and training of those psychologists who will deal with health issues.

MODELS FOR EDUCATION/TRAINING

Although the topic of research and practice in "health" appears to fit quite neatly into the interface of social and clinical psychology and may represent the "where" many psychologists have ended up, the "how" of getting here is less clear. As we noted earlier, training in health psychology has become increasingly formalized, with nearly 100 doctoral and postdoctoral health psychology training programs documented (e.g., Belar & Siegel, 1983; Belar, Wilson, & Hughes, 1982). We describe three different approaches to training. The fertile diversity of these programs suggests that premature formalization of curricula may be detrimental to the evolution of the interface of social and clinical psychology.

A Multifaceted Model

This model evolved in a southeastern university familiar to us. The psychology department offers training in traditional areas of clinical and experimental psychology, as well as specialized training in applied developmental, clinical-child, and pediatric health psychology. The health area evolved such that it is represented in three distinct programs in biopsychology, behavioral medicine, and health psychology.

The biopsychology program was designed to offer consistent research training in the areas of neuroscience and behavior. Students take a set of psychology core courses as well as neuroscience/behavioral medicine/health psychology courses. In addition, coursework in anatomy, physiology, pharmacology, and immunology is encouraged. Research emphasizes health-related neuronal and electrophysiological studies relevant to health and disease.

The behavioral medicine program provides systematic research training and relevant coursework geared toward the psychosocial and biobehavioral factors involved in the etiology, pathogenesis, and treatment of disease as well as disease prevention in people at high risk. The program is built on a traditional scientific paradigm emphasizing experimental methods, statistics, and psychophysiology. Interdisciplinary research is encouraged, and in fact research is the continuous thread tying the program together.

The health psychology program is geared toward students who wish to be both academically and clinically prepared for careers as clinicians and researchers in health settings. The program includes traditional clinical coursework, some of the behavioral medicine coursework, and both research and practicum experience in health psychology. Although this program is relatively more oriented to clinical than experimental psychology (requiring a predoctoral internship in clinical psychology), there is nevertheless an ongoing emphasis both on research and practice.

A Mixed Model

The training methods described so far are geared toward psychology students, albeit students who may have varied backgrounds and in-
terests. A heartening example of an innovative, and truly interdisciplinary, training approach was offered by Winder, Michelson, and Diamond (1985). They discussed a pediatric practicum training model that includes a multi-focus training approach geared toward pediatric medical residents and graduate students from both developmental and clinical psychology. The intensive, 2-year practicum training experience involves multiple components. For the psychology students, background coursework (required for clinical, encouraged for developmental), group supervision (a minimum of 8 work hours per week in a medical setting), and specialized workshops are a central part of the training process. Additional components involving both pediatric residents and psychology students include advanced coursework in normal child development, a course of pediatric and perinatal medicine, a series of workshops, and interdisciplinary case conferences.

Several aspects of the program are noteworthy. What is apparent from the program description offered above is the substantial time commitment required of both students and supervising faculty. A 2-year training program is much more than what is involved in a typical practicum; it is a substantial training experience that produces pediatric psychologists. Another important aspect is the truly interdisciplinary nature of the program. Psychologists and physicians learn together, consult together, and although the process is imperfect (e.g., difficulties emerged with the physician-to-psychologist referral process), it represents a truly collaborative learning experience.

Finally, the collaborative learning experience occurs within psychology as well as between psychology and medicine, combining "... both clinical and developmental models in an integrative approach to the learning of psychology in both theory and practice" (Winder et al., 1985, p. 734). Although the authors noted that some psychologists may object to shared training for both developmental and clinical psychology students, they also acknowledge that "the philosophy of training subscribed to by this program includes the recognition that psychologists may become health care providers by a variety of routes" (p. 736).

The wisdom of this catholic approach to training is underscored by research that obtained responses from 686 pediatric and health psychologists. Assessing graduate training, Stabler and Mesibov (1984) noted

Although about 65% of both pediatric and health psychologists were trained in clinical psychology training programs, another 33% had very different training experiences. Pediatric psychologists who were not trained in clinical programs were primarily trained in developmental, educational, and school psychology programs ... Health psychologists who were not trained in clinical programs were primarily trained in social and experimental psychology programs. (p. 149)

Social-Counseling Training

As noted earlier, there has been some suggestion (S. S. Hendrick, 1987) that social psychology would find a much happier, more natural alliance with counseling psychology than it has ever found with clinical psychology. Reasons cited were counseling's basic stance of cooperativeness, a likely egalitarian relationship between social and counseling, and the traditional concern of both areas with normal (rather than deviant) human behavior.

Rather than continue to talk about the potential for cooperativeness, several faculty in the Department of Psychology at Texas Tech University (Lubbock) decided to try to develop a social-counseling track to train a few select students. The program admitted three students in the fall-winter of 1986 in a training pilot study. Admission of the students was followed, rather than preceded, by some formalization of course requirements, qualifying examination emphases, and norms for ongoing research. Development of the track was done with two particular goals in mind. First, several social and counseling faculty were doing research in and/or were particularly interested in the interface area and wished to further legitimize the area within the Psychology Department. Second, there was a real desire among the faculty to train students who would have the professional training so useful in today's competitive job market as well as the thorough grounding in the research process that is the real basis of traditional psychology. It is worth noting that at least one other program at another university, attempting some of the same goals, has added a 5th year of training to the traditional 4-year curriculum in order to accommodate specialized training in health psychology. It was Texas Tech's intention to try to integrate coursework in such a way as to add as little as possible to a student's course load (perhaps just one semester). An essential requirement was, of course, ongoing involvement in research, prefera-
bly research within the interface. An example social-counseling course plan is shown in Table 39.1.

Because all graduate students in the Psychology Department are required to take a number of courses known as the departmental core (e.g., two statistics, personality, social, developmental, history, physiology, learning), these courses would serve “double duty” for the social-counseling student. In addition, students typically have a 15-hour minor in an area outside the major (though often within the department itself). Thus, hours in each of the two areas could count as a formal minor for the other area. Counseling students are required to take four practica, though students frequently take more. Social-counseling students are urged to take only the required practica and to use any extra time fulfilling other requirements and conducting research. Not infrequently, students in social or industrial/organizational take courses in intelligence testing, vocational psychology, and ethics as part of their graduate training, so these courses can be considered as contributing to a student's training in both social and counseling. Still other courses may be counted as electives for either social or counseling. Although research involvement is required of counseling students for at least two semesters prior to beginning work on the dissertation (and is encouraged for all semesters), students in social and social-counseling have ongoing research involvement, which adds to the workload. In addition, certain courses in assessment and selected other areas may be less relevant to social psychology but are essential for a fully trained professional counseling psychologist.

Although planning coursework was not too difficult, other important graduate training experiences that had to be addressed were qualifying examinations, dissertation, and internship. It was determined that, at least on a preliminary basis, the social-counseling student would take qualifying examinations in the counseling area, with part of that examination, or a separate, somewhat more circumscribed examination, administered to fulfill the social requirement. The dissertation and internship were easier to design. The dissertation would involve a topic within the interface area and would be directed by either a social or counseling psychologist, with a member of the “other” faculty serving on the committee. The question on internship was relevant to the counseling training as well as to the student’s potential licenseability as a psychologist. It was decided that any intern-

ship in a traditional counseling psychology setting would be acceptable, unless or until true interface internship sites might be developed (which could be done relatively easily in college counseling centers or community mental health facilities).

We are still in the early stages of this training program at Texas Tech and are not yet in a position to evaluate its success. Our first students are progressing well, though none have actually graduated as of this writing. We hope to attract other students to the track, but we will have somewhat more wisdom about the program they might follow. We have found that laying out a sequence of courses on paper is quite different from living through those courses with a particular student. Courses do not always get offered when they should; sometimes it seems that every needed course is offered in the same semester, if not at the same time. In addition, taking three courses, practicum, research, and typically working half-time is exhausting. Thus, proceeding through the curriculum outlined in Table 39.1 in lock-step fashion is probably not possible, and not necessarily desirable, for many doctoral students. In this respect, the social-counseling track is no different than any other graduate training program. Down the road, it may be that to be both realistic and honest with students, we will have to describe the track as “5 years plus internship” rather than the current “4 years plus internship.”

On the up side, we have attracted quality students who have good ideas and are willing to work on them, and who effectively bring together both concepts and faculty from social and counseling psychology. More faculty time and energy will have to be devoted to program formalization in the near future if this special training experience is to succeed. However, refitting the program is not one of our goals. Currently, many things are not even written down, much less written in stone.

Although these various training models are interesting, it is reasonable to wonder whether they offer us anything drastically different from the Boulder model, or even from the training/education that preceded that model. Psychologists have always been encouraged to read widely, beyond narrow and parochial limits. In fact many psychology programs employ a core curriculum that draws broadly from the varying areas of psychology. Applied psychologists read the works of interpersonal theorists and explore the implementation of various social psychological theories in the
therapy context, although similar training of experimental psychologists in “applied” knowledge occurs less frequently. And certainly the Boulder model stresses that clinical and counseling psychologists should be trained as scientists first and practitioners second.

We believe that these specific training models offer new commentary, above and beyond what has gone before, however. They make explicit what has been implicit and formalize what has been done sometimes on an ad hoc basis. To the extent that formalization turns interface training into just one more rigid professional training paradigm, we have regressed. But to the extent that it legitimizes interface training, we have progressed. In addition, to the extent that such models pay more than lip service to scientist-practitioner training, with “scientist” assuming its rightful place, we need to employ them more widely.

THE FUTURE

We have reprised the history of the social-clinical counseling interface and have presented health psychology as a rapidly growing specialty area that has some lessons to teach the interface, another rapidly growing specialty area. We also have offered several training models that might serve as the basis for training in the area of social-clinical-counseling. However, we have thus far been more interested in raising issues and questions than in providing (premature) answers. We believe that it would be short-sighted to consider education at the interface without also considering the direction(s) in which the larger discipline of psychology seems to be moving. Such directions were considered by the National Conference on Graduate Education in Psychology, held in June of 1987 at the University of Utah, Salt Lake City. In addition to specific resolutions endorsed by the conference participants, a number of scholars critically considered the present and future of the discipline (e.g., Altman, 1987).

Resolutions

There were 11 major resolutions, all containing subresolutions and proposed mechanisms by which the various resolutions could be implemented:

1. On the matter of a core curriculum, although breadth of curriculum and coverage of essential basic content areas appeared to be well accepted, definitions of a core were left up to individual departments and schools.
2. Support was given to broad liberal arts training for undergraduate psychology majors, with increasing specialization through post-doctoral work.
3. Although psychology doctoral work is usefully taught in a number of settings (e.g.,

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Table 39.1. Sample Course Schedule for Students in the Social/Counseling Program at Texas Tech University, Lubbock

<table>
<thead>
<tr>
<th>FALL</th>
<th>SPRING</th>
<th>SUMMER I</th>
<th>SUMMER II</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1 Experimental design</td>
<td>Multivariate</td>
<td>Personality</td>
<td>Research</td>
</tr>
<tr>
<td>Social seminar</td>
<td>Physiological</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vocational 1</td>
<td>Vocational 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prepracticum</td>
<td>Social applications to counselling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Research</td>
<td>Research</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2 Learning</td>
<td>Social (core)</td>
<td>Counseling</td>
<td>Research</td>
</tr>
<tr>
<td>Social-Attitudes</td>
<td>Social-small groups</td>
<td>women</td>
<td></td>
</tr>
<tr>
<td>Intelligence testing</td>
<td>MMPI</td>
<td>Ethics</td>
<td></td>
</tr>
<tr>
<td>Practicum</td>
<td>Practicum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Research</td>
<td>Research</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 3 Advanced Child</td>
<td>History &amp; systems assessment</td>
<td>Assessment</td>
<td>Research</td>
</tr>
<tr>
<td>Social-applied</td>
<td>Social systems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advanced theories</td>
<td>Practicum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Research</td>
<td>Research</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 4 Dissertation</td>
<td>Dissertation</td>
<td>Internship</td>
<td></td>
</tr>
<tr>
<td>Year 5 Internship</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
arts and sciences, education, business), non-university-affiliated freestanding professional schools were discouraged.

4. Program quality control is necessary; however, there are diverse criteria for measuring quality. Accreditation by the American Psychological Association is one (but only one) such criterion.

5. Psychology should be involved in assisting its graduates to market themselves successfully in both the academic and nonacademic work worlds.

6. Psychology needs to focus strongly on both recruitment and retention of graduate students, particularly those students from underrepresented groups.

7. There needs to be increasing attention to cultural diversity in psychology (in students, faculty, and curricula).

8. It is psychology's responsibility to aid in the informal socialization of its students.


10. Greater communication among subfields of psychology is essential.

11. Although attention has been focused on psychologists as researchers and practitioners, the psychologist as educator is extremely important.

Though all of these resolutions seem reasonably congruent with psychology as we know it, four of them appear particularly appropriate to education at the interface. Resolutions 1 and 2, supporting broad undergraduate education and increasing (though not narrow) specialization through postdoctoral work, as well as a psychology core curriculum, means that students trained at the interface need thorough grounding in traditional psychology before venturing too far into interface work. The necessity for psychology to market its graduates seems wholly congruent with interface training, itself designed to equip students well for either academic or more service-delivery roles. The resolution perhaps most important to the interface is that calling for greater communication among psychology's subfields. That in fact is one primary basis for the interface; the bone and sinew of interface education is collaboration.

Learning From the Past

If we do not learn from the past, we are doomed to repeat it, a sage once said. In discussing the forces for convergence and divergence in psychology over the past 100 years, Altman (1987) commented that there is a natural ebb and flow to this process. Outlining a number of the professional, social, and political forces influencing the process, Altman observed that psychology exhibits the effects of substantial divergent, or "centrifugal" forces at the present time, and this direction is unlikely to change.

One of the characteristics of centrifugal forces is that they pull an organism apart, and that has been an ardent concern of many contemporary psychologists. However, an equally dangerous phenomenon occurs when such forces are suppressed in the service of "unity." Diversity can be enriching, and as Altman (1987) noted, "centrifugal trends can infuse the field with new ideas" (p. 1069). Perhaps the interface is one such new idea.

REFERENCES


Hendrick, S. S. (1983). Ecumenical (social and
clinical and x, y, z . . . ) psychology. *Journal of Social and Clinical Psychology, 1*, 79–87.


