

Reflections on Training: Donald Peterson Talks With the First PsyD and a PhD Classmate

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Graduate education as preparation for the changing roles of professional psychologists is discussed by the first Doctor of Psychology in the United States; a PhD colleague who is currently director of a university-based clinical training program; and Donald Peterson, their advisor and program director in graduate school. Topics include subsequent careers of both graduates, values and limitations in their respective educational experiences, and the views of all participants on graduate education for practice and research in psychology. Such current issues as managed care and prescription privileges for psychologists are also considered. The discussion concludes with agreement that the essential qualifications for entering students are the abilities to think critically and act compassionately.

By spring 1967, the Doctor of Psychology (PsyD) program at the University of Illinois, the first PsyD program in the United States, was ready to accept students. All necessary approvals had been obtained, funding secured, new faculty hired, curriculum planned, and procedures for admission of applicants endorsed by faculty. At that time, Thomas Reid, who had previously been admitted to the long-established PhD program in clinical psychol-

ogy at Illinois, requested and was granted transfer to the PsyD program. He entered the program in September 1967. By completing his graduate studies in 1971, 1 year ahead of the first full cohort of students, Reid became the first PsyD.

At the same time, George Allen, along with a group of students that included Thomas Borkovec, Edward Craighead, Donald Meichenbaum, Daniel and Susan O'Leary, Richard Price, and a number of others who have become well known for their work in clinical and community psychology, was continuing his studies in the Illinois scientist-practitioner program that led to the PhD.

Thirty years later, following a suggestion by the editor of this journal, Reid and Allen met with Donald Peterson, director of both their programs and academic advisor to both during their graduate studies, to discuss a range of issues in the preparation of psychologists for careers in the profession and science of psychology.¹ The meeting took place on February 12, 1998, the day after Peterson had led a colloquium with faculty and students in the psychology department at the University of Connecticut. The conversation ran long, yielding a transcript of 38 single-spaced

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¹ One reviewer of the manuscript for this article found the absence of women from the dialogue "jarring." In the years Reid and Allen were admitted to graduate study, and for long years before, few women were allowed to enter doctoral programs in psychology under tacit policies that were blatantly sexist and have since been judged illegal. At a meeting of the policy-setting "advisory committee" of the University of Illinois psychology department in the mid-1960s, an influential professor proposed that choice between two equally qualified applicants, one male and one female, should favor the male, on grounds that "we get more mileage out of the men." Not one of the 12 members of the all-male committee offered so much as a murmur of dissent. None of the reviewers noted that all the authors are Protestant, heterosexual, Anglo, White Americans, but those are other stories.

pages. Abridgment to a size suitable for publication was clearly required. In the editorial process, several topics of more parochial concern than general interest were omitted, some lengthy discussions were abbreviated, and some amendments were inserted to improve clarity and coherence. Throughout the following record, however, the basic sense and substance of the original conversation have been preserved.

The Practitioner: Into the Field

Peterson: Let's start with you, Tom. There you were, admitted to the PhD program, the PsyD program came along, and you switched over to it. Why did you do that?

Reid: Well, it was relatively clear to me that I was probably going to pursue some form of practitioner's life more than the life of an academician.

Peterson: You knew that coming in?

Reid: As much as I understood what professional psychology was. What graduate student coming in really knows the field? I didn't preclude the possibility that I might see things differently after awhile, but my inclination coming in was that I was probably going to want to be a practitioner of some sort.

Peterson: And here, for the first time, was a chance to prepare for that, with official blessing by the department, and you took advantage of that.

Reid: Right. I switched because I could. Simply that.

Peterson: Did you get the education you needed? Here you are, well along in your career. You've done many things by now. Did you find your preparation suitable for the things you wound up doing?

Reid: As much as I think could have been understood about what was going to be needed down the road. I think it was truly great preparation. Hindsight suggests that some stuff was missing, but I'm not sure all that could have been known at that stage in development of the curriculum.

Peterson: Well, I certainly didn't have a perfect vision of the way the field was going to turn. I had a rough idea about where it was going and where it ought to go, but no clear prescience of the future. You've had a rather varied career. Say something about that—the kinds of things you started out to do, what you moved to then, and what you're doing now.

Reid: All right. I think the foundation in client assessment, treatment planning, and conducting treatment was the foundation of training that led me into the field and doing what I subsequently did. But I also got into community psychology—the notion of program development. That really caught my interest, and that's where my career began, in community program development in a community mental health center, doing work with school systems, police departments, probation departments. Those were the days when the runaway problem was huge nationwide. There was a lot of substance abuse, a lot of young people on the street unsupervised. Trying to find ways for a professional, with formal training, to relate to them informally was very exciting to me, partly because there weren't a lot of practitioners doing it. That made it all the more exciting. It was a new opportunity for professional psychologists.

Peterson: Yeah.

Reid: So I did that for awhile and then moved through the

administrative hierarchy in the community mental health network. I was an assistant director for a couple of years, and I was director for about 20 years. The program became well regarded throughout the state. Actually, George [Allen] had some students who participated in some committee work involving community mental health programming. People trained up here [University of Connecticut at Storrs] with progressive ideas had an interest in the work we were doing down there [Greater New Haven area]. Our program became a statewide network. We received some recognition for the work we were doing, and that was great, though I think it ultimately became a place where I stayed too long. A bit of stagnation set in.

Peterson: And you had an impulse to move on, to keep finding a new challenge and looking into that?

Reid: Yeah, that happened. Along the way, aside from mainstream community mental health center activity, I always did some part time consulting or teaching on the side. I taught at five of the universities around the Greater New Haven area as an adjunct faculty member. I did some consulting, training with the state police academy, and applied research-related activity.

Peterson: I noticed some 15–20 publications and papers you had presented at various conventions and public service agencies.

Adapting to Change

Reid: Yes, I did that. I was always doing some different things, partly because those things interested me, but partly as a kind of self-stimulation to keep myself professionally alive and active. My setting was unusual in that the town, a suburban community, had put a lot of money into the mental health program, but then, during the Reagan era, they began to ask themselves, "Why are we doing this as opposed to privatizing this kind of service?" You could see the handwriting on the wall at that point. I also saw that this was the beginning of the managed care era. I was already doing some behavioral healthcare privately, in the rehabilitation of injured workers. There were lots of injured workers. They were staying out for long periods of time, accepting workers' compensation without returning to their jobs. Finding ways to help people redefine who they were going to be, within themselves and in the workplace, was something I thought I could do. I did it because it was something I had learned about, I was interested, and also at one point it was relatively lucrative to do that kind of work. So I actually had a side career in that direction. But then managed care really began to hit the workers' compensation arena too, and when it became clear to me that I would need to move away from community mental health activity, at least in that particular setting, more involvement with workers' compensation didn't appeal to me.

Peterson: Because of managed care?

Reid: Yes, mainly that. So I began to ask, "What direction should I take? What's the trend in the field? Where is service going to be needed? Where is it going to be reimbursable? Where is it going to be fun to work?" And I began to look at this whole area of geriatric programming. An opportunity came up with a company in Massachusetts that delivered interdisciplinary services in nursing homes. They used nurses, psychiatrists, psychologists, social work people in a collaborative endeavor to deliver mental health services in convalescent homes. They were going to start up

a program in Connecticut. I interviewed with them and they asked me if I would be the startup person to get that going. I already had some administrative experience. I knew how to do hiring. I knew how to do training and orientation. I knew how to work in an interdisciplinary situation. Those skills stood me in good stead for the job. We got the program off the ground. We had 30 contracts in nursing homes within 7 months and about 15–18 employees delivering care.

Later, the company sold the Connecticut piece, which was making good money, so there was a parting of the ways, but by this time I had developed some skills with the geriatric population. I became knowledgeable about the Medicare system, the Medicaid system, how to work in nursing homes, the kinds of problems geriatrics had. If you had told me 10 years before, "Reid, you are going to be working with geriatric patients at this point in your life," I'd have said, "Get out of here. It's not going to happen." Yet I found it to be much more rewarding and exciting than I had imagined. What are you going to do with an elderly person? How are you going to talk about changing meanings in their life so that they really feel like "keeping on keeping on"? I think I had a preconceived idea that this would be boring. What I discovered was that it was much more complex and interesting than I had ever imagined.

During this time, my own mother had become elderly and infirm and had to go through the whole process of home-based healthcare, convalescent home care, psychiatric consultation. When my mom needed care, I called up a psychiatrist I knew, a man named Alan Siegal, trained at Yale, very well regarded, now past president of the American Geriatric Psychiatry Association, who had developed a multidisciplinary, outpatient–inpatient private practice. So then when the company I had been working for was sold, I went to him and said, "Do you have a psychologist in your practice?" and he said, "No, but it's not a bad idea." So at that point I moved into this fairly large interdisciplinary practice in geriatric and adult psychiatry.

Allen: I want to interject . . . A lot of psychologists today are concerned about the rapidly changing managed care market, but in listening to your history you're describing a steady rate of change throughout your career. You've taught, you've done private practice, you've done community work. So you've demonstrated two things: lifelong learning and adaptability to a constantly changing environment. What, either in your personal style or your graduate school preparation, enabled you to become a lifelong learner?

Peterson: That's a good question.

Reid: It's a great question, George. In a lot of ways, it was the graduate school training. At first, many of us went in thinking we were going to become clinicians—therapists and diagnosticians. What I came out with was how to be a problem solver. To see problems not as weighty obstacles but as challenges of life that open up inspiration and possibilities. Out of curiosity, I went to see Julian Rappaport, a bit of a lone ranger in his first year at Illinois . . .

Peterson: But very much a part of our program from the start.

Reid: . . . and he exposed me to the possibilities in community psychology, opened my thinking to applications of psychology over a broader spectrum of opportunities.

Peterson: Led you to be looking where the problem was and seeing if your knowledge and skills could bring something to that.

Reid: Right.

Allen: That was a very exciting idea both for PsyDs and for PhDs. You would not just develop interventions and do evaluations and research on individuals, but you would be looking at individuals in various kinds of public sector service settings. Could I meander a bit here?

Peterson: Meander away.

The Nature of Prevention

Allen: I thought that the community psychology movement in many ways was very promising theoretically and conceptually, but it contained the seeds of its own demise.

Peterson: What do you mean by that?

Allen: That is, a truly preventive program would kill the need, the obvious need for that program.

Peterson: That's what a lot of community psychologists were out to do.

Allen: Right. To obviate social needs in such a way as to remove the need for the preventive program. But the way most programs are funded is that the funders count heads. If you have a true preventive program, you cut down the number of people coming through the program, and then administrators and legislators will think you need less resources because you're not servicing as many people as you were before. I think that's changing, particularly in the area of healthcare. We now have computer-based algorithms that project cost savings over a 5-year period for programs in lowering blood pressure or cutting down cholesterol or triglycerides. So we can show a long-range financial saving. Corporations are moving in that direction too. State governments, where the budgets tend to be of shorter duration, are slower to adopt these kinds of preventive approaches.

Peterson: Well, getting people to look beyond the quarterly balance sheet is part of our challenge, but let me go off a bit on the idea of successful community programs eliminating the very conditions that justify their existence. I think that's an oversimplified idea of prevention. What usually happens is that we just exchange one set of problems for another, in the hope, and often in the reality, that the new situation will be better than the one it replaced. Dorothea Dix got the insane out of prisons and poorhouses and put them in asylums. But then the idea that craziness was a disease took over, and the asylums became hospitals that filled up with people nobody knew how to cure. So in our time we got rid of the hospitals, without providing the right kinds of community programs to take care of people coming out of the hospitals, and we wound up with a lot of psychotics wandering the streets, homeless and unsupervised. These days, if you read journals like *Professional Psychology: Research and Practice* [e.g., June 1997 issue], you'll see psychologists and other professionals trying a lot of different ways of dealing with the problems of the seriously mentally ill.

I think that's the way it goes. I can't imagine a society that can't be improved. You solve one problem, and then the situation changes, and there's another problem. What professional psychologists need to do is be sufficiently versatile so that they can move to the new need when it arises. To recognize a need to begin with. Then to develop a way of looking at it that is different from the way a casual observer, or even a professional from another disci-

pline, would look at it, and deal with it as well as possible. Then when that situation is a little better and resources in the society flow in some different way, we better be ready to jump. In fact, to any extent that we're ready to jump ahead of the natural social process, to anticipate some of the changes, we'll be better off as professionals, and at the same time we'll be doing more good for the communities we're supposed to be helping.

Allen: That's exactly what Tom did in his career. He anticipated. He jumped.

Peterson: Precisely. He's a perfect example. It isn't so much problem solving. It's problem studying, to guide efforts toward solution that are then examined and lead to new efforts toward solution if the first efforts don't work.

The Core of Practice

I want to get back to Tom's approach to professional work and how he developed it. What, as a psychologist, did you bring to the services you mentioned that other people did not?

Reid: I think . . . the idea of practice as disciplined inquiry that you have written about. Starting with the client, the assessment, attempted intervention as functional analysis, reviewing outcome, recycling it and reformulating intervention if it's needed or leaving with what you've done. I hadn't seen your diagram of the process before I read your book (D. R. Peterson, 1997, p. 52; see also D. R. Peterson, 1991, p. 426), but if you had asked me to draw it, sight unseen, I could have drawn it. And the reason I could have drawn it was that that's the most significant piece of learning that came out of my graduate education—the notion of a scientific approach to a problem and addressing it in a well-organized way. That's what I've brought to every situation I've been in—a way of looking at a multitude of influences, a way of organizing the information such that you can actually do something with it and make sense out of it.

Peterson: What was missing in your education? What wasn't there that you found you needed to know in the varied career you've had?

Reid: That's interesting. I think when I came into psychology the clinical psychologist was still pretty much seen as a clinician.

Peterson: You mean as a psychotherapist.

Reid: Yes, a psychotherapist, and an individual therapist as opposed to group-related work. So working in groups was important. One of the ways I got exposed to that was to go to Merle Ohlsen in the educational psychology department. Ohlsen was president of a group psychotherapy association at the time. I said I wanted to learn something about groups and he helped me do that. Julian [Rappaport] started working in communities. I think one of the things that was missing at that point was a general orientation and a broad spectrum of exposures from the clinical department to industrial-organizational consultation, group-related, individual-related, community-related, program evaluation-related work. I don't think that was available because we weren't thinking in those terms at that time.

Peterson: Well, my book, *The Clinical Study of Social Behavior* [1968], which you read, was an early effort to establish a strategy of inquiry that would be pertinent at the individual, group, organizational, and community levels, and once full classes of students started coming in, I think I did a better job of laying out

the big picture. But you're right, we didn't do as well as we might have in teaching students what comprehensive professional psychology amounted to. The concept was there, but opportunities for experiential learning at all those levels were lacking.

Reid: Sure. Another thing that was missing was the business management side of being a professional psychologist—understanding issues of managed care, marketing, how to present ideas, being trained as a teacher, a lecturer, a public speaker. So the business piece and some of the broad spectrum material was missing. But you know, I have never gone through my career saying, "Damn! I was inadequately prepared." If anything, my training was just the best, given the state of knowledge at the time.

Peterson: And since then, as new information came along, and new ways of looking at things and finding out about them developed, you were able to learn about them and apply them.

Working With Other Professions

Reid: I think the skills we're talking about here are important for graduate education to engender. To establish the identity of the student as a psychologist. To take that on like a mantle. "Now, I am one of them! That's who I am." However, when you move into the practitioner's environment, you're often not among psychologists, or at least not only among psychologists. You're there, these days, with physicians, nurses, marriage and family therapists, social workers, and now master's level psychologists are licensed practitioners in many states. How will I maintain my identity and my special expertise in the presence of a network of other practitioners?

Peterson: That's a big issue. Psychologists need to preserve their identity as psychologists and at the same time learn to complement, to learn from, to form effective alliances with other disciplines. I think we're getting there in some degree, but I think we've devoted ourselves all too much to competing with psychiatrists for a limited kind of mental health trade. One of the ways we can move is to form partnerships with physicians in other health-care specialties—with cardiologists, oncologists, pediatricians, all the rest—and do the kinds of things that medical people don't know how to do, don't want to learn how to do. Likewise, affiliation with lawyers, the court system, probation officers, people in the broad field of correctional and forensic psychology. Work in the business world, the way I/O [industrial/organizational] psychologists have all along, schools, government—learn to form partnerships and alliances in the interest of better public service. It seems to me that's the direction we have to take, not only for the benefit of society, but for our own survival. I don't think we're going to last unless we learn how to do this more effectively than we have in the past.

Reid: That's the direction I've been thinking about too. But this whole issue of differentiation of the psychologist as a practitioner, yet integration with other practitioners, is very much of a push-pull situation. I'm part of a team that has exercise physiologists, nutritionists, physicians, nurses, all those. But I'm a psychologist. What do I bring? How do I maintain my autonomy and integrity as a psychologist, and just how do I collaborate?

Allen: One specific role we have as psychologists is as specialized evaluators. Right now I have two graduate students working as part of a multidisciplinary health and wellness program in an

industrial setting. They're working with graduate students in nursing, nutritional sciences, and exercise promotion in running stress management programs for senior management. We have two roles in the project: running workshops and evaluating the efficacy of many other interventions, such as blood pressure and cholesterol screenings. That places our psychologists in a very important position in the team, but it also creates some problems. I've had to fend for students so they won't have to do the whole evaluation in addition to doing their kinds of interventions. The nurses do blood pressure screenings. Why should the clinical psych. students do evaluation *and* intervention? We've dealt with that problem by educating the others about how to embed useful evaluative components within their practical activities. As psychologists, we consult with the other practitioners about how to evaluate their parts of the work. They provide the data. We analyze the data they collect and oversee the whole evaluative process.

Reid: That's great. We teach others and we learn from them. I know a lot more about antidepressants now than I ever learned in my medical psychology courses at Illinois. That's another thing that was missing, by the way—more on the biological foundations and treatments of mental illness.

Prescription Privileges?

Peterson: Yes, we made a pass at it but didn't really do enough with it. What do you think about prescription privileges for psychologists?

Reid: I knew you were going to ask that. I just knew it.

Peterson: It's in the air. What are your thoughts about that, Tom?

Reid: Before we started recording, I said there were some issues about which I don't have fully formed ideas. This is one of them. There's part of me that says that whether or not psychologists prescribe, they need to know a lot about psychotropic drugs, but whether they ought to have a license to prescribe is still a question in my mind.

Peterson: I'm ambivalent too. Drugs are already overprescribed, vastly. Are we going to fall into the same trap—a simple pill approach to problems that are in nature much more complex? And will we just become junior psychiatrists? That's a fear that bothers me. Yet I've come to the view that for the sake of our clients it would be well for at least some fraction of psychologists to become prescribing psychologists. There are times, as you well know, when it's a good thing to give an antidepressant drug or an anxiety-reducing drug to a client, especially in combination with behavioral procedures. So, if I'm serving my client best, why should I have to send him to somebody who knows every bone in the foot and a lot of other irrelevant stuff? Why wouldn't it be better for the client if I can just write out a prescription? You don't need to have an MD to employ psychotropic drugs in an effective fashion. The main indicants for their use are not physical: they're behavioral. That's our specialty. We're supposed to be good at assessing behavior, and my unstudied observation about medical people generally is that they're not very good at doing that. I'm prepared to make a bet—that psychologists will make no more mistakes than the medical people. I think we can do better. But the training programs are going to have to be very good, and we'll

have to be careful not to lose our psychological center—our unique contribution to the whole show.

The Scientist-Practitioner

I'd like to hear some more about your education, George. Tom moved over to the PsyD program, but you stuck with the PhD program, and you've had a long and varied career as well. How has that gone?

Allen: It's been a wonderful career. I came late to psychology. I was a sociology major as an undergraduate, and I turned down a mathematical sociology fellowship for graduate school because I didn't know what mathematical sociologists really did. I gave that up and went to Boston College to get a master's degree in experimental psychology. I was influenced heavily by Joseph Cautela and ended up at Illinois, primarily interested in studying anxiety processes.

Peterson: Gordon Paul had just done his desensitization study [Paul, 1966].

Allen: Yes. I had always felt like a natural helper. People would come to me with issues and problems. In my desire to know more about anxieties what we were doing at Illinois was very exciting. We brought in three new faculty members, one of whom was also interested in anxiety. That was Doug Bernstein.

Peterson: You did your dissertation research with him.

Allen: Yes, on desensitization and study counseling in relieving test anxiety [Allen, 1971].

Peterson: And you won an award for it. I've read some of your publications [e.g., Allen & Sheckley, 1992]. You've continued your interest in studying anxiety problems, but the way you are looking at them today is not the way you looked at them when you were studying at the University of Illinois. Am I right about that?

Allen: That's absolutely right. I've noticed not only in my own career, but in the career paths my colleagues took, that we started out doing classical, experimentally designed outcome studies.

Peterson: Carefully controlled, group factorial studies.

Allen: And over time, we moved toward attempting to understand the basic processes involved, and, not coincidentally, toward creating and implementing more sophisticated measurement strategies and devices. It's a curious kind of inversion. You'd think you'd pay attention to the measurement issues first and then move on to the interventions. But the career paths of people in my area of research show that they started with intervention and then got increasingly interested in more sophisticated assessment of the phenomena.

Peterson: Sure. We're interested in outcome, but outcome relates to process, and process relates to outcome, and the more you study any of that the more you appreciate the need for ever-better assessment. That's why I talk about disciplined inquiry as the core function of the professional psychologist. The kind of recursive, circular model of examination and intervention you are employing in your research now seems to me a perfect example of the linkage between process and outcome that we have to pursue. It holds in the study of individuals, it holds in the study of groups; as far as I'm concerned it holds in the study of communities as well.

Reid: You were talking about the notion of interventions leading to a greater desire to refine measurement. For me, sometimes

that occurs when I discover that the intervention I designed with a client or community group is inadequate. It doesn't get the whole picture. There's something in the phenomenon I haven't conceptualized, and that says, wait a minute, there needs to be a better way to measure it so that you can actually identify it.

Allen: And then you go back to the drawing board.

Reid: Exactly.

Peterson: With a different way of thinking about it than you had going in. You start with what I call a *guiding conception*. It's not a clearly established theory, but it's a conception of the phenomenon you're trying to understand that tells you what to look for. It doesn't tell you what you're going to find, but it tells you what to look for and in some measure how to do the looking. You remember in my *Clinical Study* book [1968] I made a case for using the methods of behavioral science in our professional work: observation, interview, functional analysis of behavior. See what you can see. That gives you an entree into any problem whatsoever. Once you examine a situation, you might say that the problem, with knowledge and resources as I gauge them now, is beyond our competence. Then you move over to another problem that you can hit with some measure of success. If we just stay narrowly with problems that we're absolutely sure we know how to handle, we'll fail to examine the most severe challenges of our day, and we'll fail to come up with what the public really expects of psychology, which is a useful way of helping our society and the people in it work better. That's what we're up to, as researchers, as practitioners.

What about your education, George? How did that work for you?

Allen: I've thought a lot about that. Let me begin by saying what experiences, what attitudinal stances, were most valuable. For me, the most important learning from graduate school was this: What was worth doing was worth evaluating in some systematic way. That's something I took to—had a strong need and affinity for—and it led me to learn a lot about different methods of evaluating. But several things were lacking, I think. We all learned a kind of midwestern scientism about what would constitute an evaluation. In my career, I've clearly moved away from that. I've published close to 100 papers, and I think the most influential one was a survey of doctoral students around the country in which I asked them what were the best and worst psychotherapy supervision experiences they had had [Allen, Szollos, & Williams, 1986]. Not a lot of experimental control. We did our sampling in a representative way, but there were no factorial designs. It was a completely correlational, descriptive study. That's the one I get the most recognition for and that people find most useful.

Peterson: What did you find?

Supervision: Good and Bad

Allen: The findings were basically that the best supervision experiences were characterized by a serious attitude toward supervision. Supervision was taken seriously by the supervisors. It's probably easier to characterize the worst experiences which were, in a minority of cases, abusive, and in a larger number of cases, impoverished. The characteristics of the supervisor that were most strongly associated with good quality supervision were expertise and trustworthiness, not sociability.

Peterson: They weren't just nice people. They knew their stuff.

Allen: They knew their stuff and they could be trusted. They didn't have to be sociable.

Reid: Arnie Miller [Arnold Miller, PhD, chief psychologist at the Champaign County Mental Hygiene Clinic and adjunct faculty in the clinical psychology programs at the University at Illinois] was like that. How many supervisors do you know who do the kind of work Miller did, who used reel-to-reel tape recorders and by the damn counter number would write comments on your comments, comments on your client's comments? You'd get back a two- or three-page, line-by-line analytical review of your performance. He listened. Oh my God! Somebody actually listened to what I said? And somebody occasionally liked what I said?

Allen: Arnie Miller was by far my best psychotherapy supervisor. Don Shannon did a similar kind of work.

Reid: For a prospective practitioner, not to have had some of that in their training would be a huge loss.

Allen: I agree. I think the same kind of seriousness has to go into research training.

Peterson: Yes, I agree with that.

Allen: I think you have to take your students literally by the hand and teach them about internal consistency, other forms of reliability, various types of validity, and derivative analytical operations. They need to read classical literature on these issues [e.g., Cook & Campbell, 1979; Cronbach & Meehl, 1955] and you have to take them, step by step, and help them apply these general concepts to their specific areas of investigation. You have to forgive lots of mistakes, but not tolerate the same ones repeatedly. You have to encourage them to take risks in interpreting what they find but not go too far beyond the data. It's exactly the same set of processes—hypothesis generation, hypothesis testing, and ruling out plausible alternatives—that you find in high-quality clinical endeavors.

Peterson: And the teachers have to be actively engaged in research themselves, bring their own enthusiasm to it, provide some experience the student doesn't have.

Who Shall Teach Practitioners?

Reid: I'm sure that's true. But we were talking yesterday about professors passing on to their students what *they* learned in graduate school. The whole business of practitioners being prepared by faculty who are academicians is an interesting issue.

Peterson: It's a paradox, isn't it?

Reid: Knowing you, Don, I would guess when you began to rely in some measure on adjunct faculty at Illinois, it was more than a manpower problem.

Peterson: Oh, it was much more. It was a matter of high principle. We had to have teachers and role models who were doing what we wanted to teach. That was a very important consideration in my mind and still is.

Reid: Arnie Miller, for me, was the epitome of a resourceful clinician who had the ability to handle whatever came along. I got to the point where it didn't matter who came into my office as a client. If I hadn't seen that problem I could figure out some way to approach it. That kind of confidence was instilled by working with clinicians in the field, doing their kinds of practice. The rigor of

how to conceptualize things I didn't get so much from them. I got that from Gordon Paul, Len Ullmann, Don Peterson, Don Shannon, people like that.

Allen: What the adjunct supervisors brought was the interpersonal connection between themselves as clinicians and supervisors, their view of you as a student clinician, and your clients.

Peterson: That three-way connection. I think you've got it, George.

Reid: I wanted to be sure we talked about that adjunct piece and how you knitted it into the training.

Peterson: It's absolutely essential. It seems to me educating people for practice in psychology is not unlike educating physicians for practice. Medical schools do not assume that every MD is going to do a lot of research. They teach them about the human body, about health and ill health, and then teach them a way of approaching the kinds of problems physicians face and how to do something effective about them. The teachers of that are active practitioners. They may be doing some research. If they are, that's fine, but the main thing they are is skilled practitioners. It seems to me our practitioners need to learn how to do what they're going to do as practitioners, and they need to learn that from people who are very skilled and experienced in doing what they're doing.

Allen: I think the faculty have to be coping models. In Bandura's [1977] terms, I distinguish between coping and mastery models. Mastery models appear to have the answers—quick and simple; do it my way. They hand you the solution, really *their* solution. Coping models struggle toward solutions and bring you along for the ride, demonstrating the processes by which they reach closure. Bandura found that people learn better from contact with coping models. At Illinois, I think we had a lot of mastery models.

Peterson: I think so too. To me, the difference is in the way you approach problems. One way is to see problems as conditions that have clear, fixed solutions. If you're a teacher, then, you show students what the solutions are. Troubles come in when the solution doesn't quite work right. The solution doesn't exactly fit the case, or there's more to it than anybody counted on. All too often, the teacher is invested in the way he—I think it's usually "he"—sized up the situation and in the solution he proposed. When things go wrong, he has to deny or distort the failures to show that he had the right idea—to maintain authority.

Allen: And really what you have throughout a professional career is constant coping with changes. Your career changes are a perfect example of that, Tom. You coped. And coping isn't easy. It doesn't mean you've got it together at all times. But you struggle, you struggle, and sometimes you succeed. And part of the healthy education of students is that they experience that kind of coping model in their faculty—that we say to them, "Oh, I was in therapy and here's what my experience was like," or, "I've done this job for 15 years and I don't feel I do it quite as well as I can yet," that we admit it when we screw something up and do our best to fix it.

Peterson: It's the other way of approaching problems. Teacher and student together look at the situation the best way they can. The teacher knows some things the student doesn't and has had some experiences the student hasn't had, but they're both, together, coping with the situation. Sometimes they succeed early, and that's great when it happens, but often the situation changes as

they go along, and then they have to cope with a new situation. Above all, they have to be ready to acknowledge and learn from their own mistakes when they make them. As a teacher, it ain't so easy. You have to relinquish some authority and work in a more egalitarian partnership with students.

Student-Faculty Relationships

Allen: I think there have been some big changes in that over the years. When Tom and I went to graduate school, the experiences students had were very different from the way students experience graduate study today.

Reid: I was talking with students at dinner last night about that phenomenon. It's true.

Peterson: It's true.

Allen: It's very different. At Illinois, in those years, I think the attitudinal stance was that students were there at the sufferance of the faculty. One of the first things I heard in my first meeting with all of the new students was that "we have taken in too many of you, and half of you will be gone by the end of the year."

Reid: I heard that too. It was frightening.

Allen: The whole issue of due process in terms of students' rights was just nonexistent in those times. At the end of my first year, sure enough some of my classmates were gone, and we had no idea why they went or where they went or what the process was by which they were kicked out. That was pretty scary stuff.

Peterson: Hard to imagine that happening today.

Allen: There was a sense too of a slightly contemptuous stance toward people who wanted to do clinical work. The message was that you were being trained at public expense and you must turn around and work for the community betterment. I think there was contempt for people who wanted to go into clinical careers.

Peterson: That's still there in many departments. That's why I talk about the need for an encouraging culture in any program that's designed to prepare people for professional work. That's one of the main reasons we have a professional school at Rutgers. The chairman of our academic department doesn't think the things we're doing in our school, except for the research, are worth doing. In fact, he recently proposed that the school be abolished on grounds that all we're doing is training psychotherapists. He's wrong about that, and our school will survive, but that's the attitude, not only on the part of the chairman, but many of the faculty.

Allen: Things began to open up a little at Illinois just as I was leaving. I remember serving as the first student ever on a search committee for a new faculty member. The idea of students not being involved in governance is just an anomaly. It makes no sense.

Peterson: It's hard to imagine any more, isn't it? It's a huge cultural change—very active engagement of students in decision-making, policy formation. All of us together, raising questions, trying to spot our mistakes and correct them.

Reid: But sometimes you can't correct your mistakes. Sometimes you only get one shot at it if you're lucky. It's not that you can find out what's going wrong and then go back and redo it.

Questions of Quality in PsyD Programs

Peterson: Oh, how true. You've got one chance. You have to do the best you can, and you don't always get it right. At the time I started the PsyD program at Illinois, I had reason to believe there might be comparable programs at the University of Minnesota, Tennessee, and New York University. It looked as if programs of the kind we were developing at Illinois might take off and become something like a national trend. As we all know by now, that hasn't happened. The major research universities have retained the kind of research-oriented program that we see here at UConn [University of Connecticut]. I think this one and others like it are better balanced than they used to be—more serious about preparing psychologists for practice, partly in response to competition from the professional schools. I'm all for programs of the kind George is running. Bless them. May they grow and prosper. And I've occasionally been in deep despair about the way the PsyD movement has gone. Some of the early programs—Baylor, the Hahnemann program now at Widener University—were soundly planned and well supported, but the idea also got picked up by some people who didn't understand what it took to run a high-quality program. They seemed to think—this may be an unfair statement, but I don't believe it is—that a PsyD program was a clinical PhD program without research. I never believed that. I'll go to the other side. I think preparation for versatile practice of the kind you're engaged in, Tom, is in some regards substantially more difficult than the preparation of researchers, for the simple reason that researchers can specialize more than practitioners can. Once you get on the faculty in most universities, you have to specialize early to make it to tenure. You have to know everything about the problem you're examining and get a jump ahead of everybody else so you have something new to say to the discipline. But in preparing somebody for versatile, changing, growing, dynamical practice, you have to have a different attitude—a broad one—some exposure at least across individual, group, organizational, and community levels—and a readiness to move where the problem is and where you might do some good. Very strong preparation in one or two forms of practice is a good idea so students can say to employers, "I'm as good as you're going to find in doing the main job you want done. If other problems arise, I can handle those too." And then be able to back up the promise with performance when the time comes.

Well, that was my idea, but that's not the way all the programs turned out. I think the weaker programs are getting stronger now, partly on their own initiative and partly through the work of the National Council of Schools and Programs of Professional Psychology. We've set very high standards [see R. L. Peterson, Peterson, Abrams, & Stricker, 1997], far beyond minimal accreditation standards, and all of the programs I know are working to meet those standards. We keep on doing self-studies and working to improve. I'm hopeful.

Allen: I think the proliferation of professional schools during the '80s coincided with a growing view among undergraduates in psychology, and probably some older people who wanted second careers, that going to graduate school and getting into practice would lead to easy money. It was an easy career. It didn't take a lot of time or energy. You would get your degree and hang out your shingle and start your practice. And I think that bent the

movement in a way which was dangerous and damaging. I think one of the things that's happening now in managed care is that this trend is being corrected.

Peterson: I think so too. I think we need to work against abuses of managed care, but in some ways managed care might turn out to be the best thing that ever happened to professional psychology. It will force us to go after the most serious needs in our society, to bring out all our discipline and creativity to meet those needs.

Allen: I think that's the hope for the future. I think psychologists, by and large, are a bright and creative bunch. I think we can handle this.

Essential Qualifications of Entering Students

Peterson: I think so too. If we can't, we *ought* to fold. We're winding down. I'd like to have a go around on one final question. If any of your children were approaching the time for career choice and said, "I'm thinking about going into psychology," what would you tell them? Tom?

Reid: I think the first thing I would tell them is that it would be a good idea to have some conversations about what you think psychology is, what it is that attracts you.

Peterson: Learn more about it before you commit yourself.

Reid: Right. I'm happy to have a conversation with you about what *I* think psychology is, but my guess is if you talk to people from several different perspectives about what they think psychology is, and what it offers, their views may or may not correspond with your imagined fantasy of what it is. You need to be thinking about a broader definition of psychology than you probably have at the moment.

Peterson: Well, George's principle—anything worth doing is worth evaluating—holds also for a person entering the field. First thing they have to do is get the best anticipatory picture they can of the field, as it looks now and as it appears to be moving, before they decide to spend their lives in it. What are your thoughts, George?

Allen: I would look at my child and ask, "Can my child think critically and act compassionately?"

Peterson: Beautiful.

Allen: And, if both those ingredients are present, I would be encouraging. If either ingredient was not present, I would be discouraging.

Peterson: I've said that students need to have their heads screwed on right and their hearts in the right place, but you've said it better. They need a capacity for and an interest in critical analysis of human problems—really getting to the heart and truth of things—and at the same time a genuine compassionate concern for their fellow human beings. With both of those, I would say yes. Without either of those, I would say no.

Reid: Amen, brothers.

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