

The revolution in the delivery of and payment for medical care in the United States is dramatically transforming the theory and practice of psychotherapy. Psychotherapists, like their physician counterparts, are being asked to become cost-effective, and therefore time-efficient, in the delivery of their services. In addition, they are being asked to generate outcome data to substantiate their clinical effectiveness. There is little doubt that many physicians, health-care personnel, and psychotherapists will find economic survival more difficult, if not impossible, in their current roles. Training programs must respond to these changing demands on practitioners in order to increase the likelihood of their surviving in these tumultuous times.

For much of this century of psychotherapy, psychotherapists have enjoyed the luxury theoretical debate. In what has been amusingly described as a "dogma eats dogma" environment, various therapist have proclaimed the superiority of their theoretical approaches. Although meta-analytic studies have demonstrated the relative equivalence of several approaches (Lambert & Bergin, 1994), and well-designed comparisons of several schools in the treatment of depression (Klerman, Weissman, Markowitz, Glick, Wilner, Mason, & Shear, 1994) have yielded little difference in the aggregate, psychotherapy debates continue, but with lessening fervor.

Over the past quarter-century, the movement to integrate the psychotherapies has accelerated (Norcross & Goldfried, 1992). Clinicians drawn more by patient needs than by theoretical allegiance have attempted to assimilate potential concepts and techniques from a variety of different schools in order to provide efficient treatment for their patients. Eclecticism has given way to several different integrative approaches, which hold the promise of providing a practical framework of decision points associated with a limited number of potentially effective strategies and techniques applicable to varying patient needs.

Among psychotherapy researchers debates abound between those who support experientially validated therapies (EVTs) and those who emphasize process variables, particularly those variables that the patient brings to therapy. This training program builds upon the process research paradigm by emphasizing the capabilities of the trainees as they proceed through the learning curve. Instead of claiming trainees are trained or indoctrinated into a specific orientation, this approach tires to build on trainee strengths and experiences by evoking and sharpening already present psychotherapeutic skills and knowledge. Like their patients, trainees vary in the critical process related to being successful in therapy , such as readiness to change, social network strengths, and ability to form therapeutic alliance.

There are currently three existing categories of training in psychotherapy. Most training programs fall in the first category. These programs appear to be rather disorganized in their conceptual presentation of psychotherapy, allowing different teachers and professors to present their own perspectives on psychotherapy through supervision and didactic seminars, and implicitly suggesting that trainees should put the ideas and techniques together in a way that suits them personally.

A growing number of training programs fall into the second category. These programs rely on manual-based approaches where trainees are expected to learn the specific techniques, attitudes, and skills associated with a certain approach, for example, cognitive therapy for depression (Beck, Rush, Shaw, & Emery, 1979), or exposure and response prevention for obsessive compulsive disorder, or interpersonal psychotherapy for depression (Klerman, Weissman, Rounsaville, & Chevron, 1984), or psychodynamic psychotherapy for disturbed interpersonal relationships (Strupp & Binder, 1984). There is much merit in such manual-guided training programs, including the relatively easy provision of outcome criteria and the confidence trainees acquire in their knowledge base. However, reasonable questions arise about the generalizability to clinical practice of manual based therapies that have been shown to be effective in controlled experimental trials.

Controlled studies screen out diverse patients in order to adhere to the uniformity demanded of research protocols (Goldfried & Wolfe, 1996). A manual-focused training program limits understanding of other possible approaches for those patients who have more complicated presentations than those addressed by protocol-prescribed approaches. In addition, trainees are not shown what is fundamental to all these approaches—the basics of psychotherapy that draw them together, making each school with a variation on a basic theme. These disadvantages have given rise to a third category of training programs, those in psychotherapy integration, where the techniques shared among the major schools of psychotherapy are emphasized. This program falls into the third category.

What are the goals of an effective residency training program? The designers of an effective training program must select a limited number of skills that, if effectively taught, will lead to effective psychotherapy. This objective requires careful selection from a wide variety of potential alternatives based on research and clinical experience. The selected alternatives should include what are generally considered to common factors in or pantheoretical element of the psychotherapies. After all, if we apply the term psychotherapy to an entity, there must be certain elements that define across the various orientations subsumed under it.

It is toward this aim that this training program is developed. In addition, this training program strives to help trainees master multiple treatment combinations and to adjust their therapeutic approaches to fit the needs of their patients. An additional goal is to educate trainees to think and perhaps behave integratively—openly and synthetically, but critically—in their clinical pursuits (Andrews, Norcross, & Halgin, 1992). Trainees are encouraged to examine their own thinking to apply critical research attitudes to what they do and how they do it. They learn to measure their effectiveness and respond to these evaluations with a sharpening behavior and thinking. Trainees should be informed consumers of research findings and should respect research evidence that can contribute to clinical effectiveness.

As suggested by Robertson (1995), evaluation of training programs is becoming more and more necessary, but current evaluations tend to be impressionistic and tend not to

link process or ongoing evaluation to outcomes with quantitative measures that are valid and reliable. This training program takes some steps in that direction.