

# **Psychologists in Non-Traditional Academic Departments**

September 08, 2003

## **Shifting Focus: The Experience of a Traditional Academic in a Professional School**

**By Larry E. Beutler**

I am a scientist-practitioner in the tradition of the Boulder Model. I have taught in three major medical schools, in a small state university, in two graduate schools, and have just retired as professor emeritus at the University of California, Santa Barbara. In the spirit of the scientist-practitioner, I have been a clinician in large and small group practices as well as in individual, independent ones. In all of these roles I have been interested in how psychological knowledge can be developed and applied more meaningfully. While I pride myself for having made many transitions and for pioneering some “cutting edge” applications of science to practice, my recent transition (since my retirement) to directing a large PhD program in a free standing professional school (Pacific Graduate School of Psychology) has required a substantially different level of adaptation.

I am employed less than full time at PGSP, and am on campus two days a week and in my home office every night. I oversee a student body of 250 doctoral students and over 20 faculty members. At some levels, the shift I have made is very subtle. For example, I maintain my commitment to both science and practice. My hope for this program, however, is not to breed academic scientists, but to create practitioners who use the scientific method to both invent new treatments and to guide their use of older ones.

Like other professional schools, PGSP emphasizes academic-scholar roles for students rather than scientist or scientist-practitioner ones. I envision our students as working at the front line, both to develop new knowledge and to apply that knowledge to program development, program evaluation, outcome assessment, and even individual patient evaluation and psychotherapy.

There are many larger and more difficult adjustments that I have had to make in assuming this position than simply altering my training model. For example, working in a free-standing professional school requires one to accept a tight and often denied link between the availability of money, on one hand, and decisions about student admission, application of student discipline, and even grade assignments, on the other. Every decision must be weighed, at least partly, by whether it will attract and retain applicants to the program. While I’ve always thought of students as the “consumers” of my work, this concept no longer holds true. Students are instead the democratic voice; they directly dictate whether my proposals will be implemented. I can no longer look beyond a given body of students to those in the future in order to seek a more distant objective. The budget, and hence the programs, are immediately affected by the decisions of a single individual not to re-enroll. I’ve become near-sighted.

The administration is also more closely involved in my decisions. In major universities, a professor is several tiers removed from the administration. In an independent graduate school, however, the designated leadership is rarely more than a step away. There is a tendency to engage in over-management. Roles blur as everyone wants to have a part of all decisions, and the organization tends to become top heavy as everyone assumes some title to designate his importance.

Then there are the students. The nature of students in a free standing professional school is different than in research universities. They require more careful handling, they are less interested in the philosophy that I enjoy so much, and they demand that you justify the practical and immediate applicability of any program or hypothesis that one advances.

In the face of challenges such as those only briefly mentioned here, I have, on many occasions, been asked why I decided to use my retirement in this way. In fact, the answers are relatively simple:

1. I assumed this role first and foremost to have the opportunity of working with some special friends and colleagues. Bruce Bongar has been a long time collaborator, and the chance of working more closely with him, Phil Zimbardo, Jim Breckenridge, and others in the Palo Alto/PGSP/Stanford community, is very gratifying.
2. I like a challenge and value opportunities for innovative program development. We have recently developed a coalition with the Palo Alto Veterans Medical Center and with Stanford Medical School. It is my challenge here to ensure continuing CoA/APA accreditation of our program. The alliances that are available to accomplish this task provide remarkable opportunities for growth and creativity.
3. My colleagues and I had, for some months following the events of September 11, 2001, discussed the possibility of developing a national center to study and develop programs that address crises of terrorism and disaster. Since moving to Palo Alto, I have been provided an opportunity to institute such a center with the help of the PGSP Veterans Medical Center and the Stanford coalitions. As a result, there is now a National Center for Disaster Psychology and Terrorism. Seed funding and some skeletal programs are in place, and we have a large body of national and international colleagues who have signed on as consultants.

Bongar, Zimbardo, Breckenridge and I believe that we can make a difference in today's world. Through the help of the Palo Alto coalition, the PGSP, and the National Center on Disaster Psychology and Terrorism, we combine old knowledge, new knowledge, and many viewpoints with a large student body to address the problems of an increasingly globalized, frighteningly volatile violence. Here is where the research and practice of psychology can really matter.

## **Workout Tips From the Exercise and Sport Science Department**

**By Diane Gill**

Unlike most others who have written columns for this series on non-psychology departments, and unlike most who will read this column, I did not receive my training in psychology. I began in exercise and sport science and I have continued to research, teach, and advise graduate students in exercise and sport science departments throughout my career. Since I began 30 years ago, however, much in the field has

changed.

After completing an undergraduate program in physical education and teaching for two years, I entered the graduate program at the University of Illinois, and quickly focused on the emerging area of sport and exercise psychology. Although I was in a physical education (now kinesiology) department, I took most of my graduate coursework in the psychology department, focusing on social psychology and statistics. My advisor, Rainer Martens, was connected with the Children's Research Center, and I assisted with several projects following the social psychological models and experimental methods that dominated at that time.

After completing my PhD in 1976, I held faculty positions at the universities of Waterloo and Iowa before moving to my current position at University of North Carolina at Greensboro in 1987. All these positions were exercise and sport science programs, and I specialized in sport and exercise psychology, with a major role in graduate teaching and research.

Sport and exercise psychology has changed over those years, and my work has changed, although I continue to emphasize social context and dynamics. Through the 1980s and 1990s, sport and exercise psychology moved away from experimental lab research and followed psychology trends in differing emphases and highlights. At the same time, sport and exercise psychology developed its unique content, with sport-specific research models and measures, and many professionals took on consulting roles with athletes.

As the research and practice of sport and exercise psychology changed, so did the students and professionals in the field. When I began my career, psychologists rarely mentioned sport or exercise, as though the topic was not worthy of psychology. Today, many of the more active researchers and consultants have all their training in psychology, and most of the students who apply to our graduate programs are from psychology backgrounds. However, most sport and exercise courses, as well as most graduate training programs, are in departments of exercise and sport science.

Exercise and sport science departments are different from psychology departments, and expectations for research and teaching are different. Exercise and sport science students and faculty are expected to have an understanding of and appreciation for an integrated, multidisciplinary field that encompasses biochemistry and socio-cultural perspectives as well as varied psychological perspectives.

Undergraduates in exercise and sport science typically aim for careers in fitness and health or sports medicine, with smaller numbers in teaching or sport management. Exercise and sport psychology courses include a wide range of topics such as motivation, stress management, and group dynamics, with specific application to sport and exercise settings. Graduate education and research is more specialized within those larger areas.

Many graduate students are interested in the broad area of "applied sport psychology" and in working as consultants with athletes. Very few graduates actually do sport psychology consulting as a full time professional, as those opportunities are limited, and many who do such work have counseling or clinical practices. Sometimes faculty members in exercise and sport science departments engage in sport psychology consulting through an educational, psychological skills training approach. More often, though, faculty in exercise and sport science are focused on their research and teaching. Those with more applied interests might engage in research related to psychological skills development, anxiety and

performance, emotional control, or team building and social support.

Many sport and exercise psychology faculty have focused their research on exercise and health, engaging in collaborative research related to physical activity for health promotion and prevention. Much sport and exercise psychology research is closely aligned with health psychology, one of the fastest growing sub-areas in psychology. Other sport and exercise psychology researchers are expanding in other ways. Youth programs focusing on the development of life skills often incorporate sport and exercise, and many psychologists from exercise and sport science departments are engaged in those efforts.

Research and practice in sport and exercise psychology continue to incorporate more sub-areas of psychology and to expand in new directions. Those who are interested in sport and exercise psychology might look to exercise and sport science departments. But it would be a mistake to limit research and practice to psychological skills training for elite athletes. Spend time considering the many ways psychology intersects with sport and exercise. Much of the research is relatively new and we have only begun to address the endless possibilities.

## **The Many Roles of a Research Psychologist in a Medical School**

**By Robert M. Hamm**

For more than 10 years I have worked as a non-clinical psychologist in a medical school department of family medicine. My colleagues are 15 physicians (many with master's degrees in epidemiology), six physician associates, and faculty with a variety of auxiliary degrees (anthropology, clinical, cognitive, and educational psychology, home economics, gerontology, clinical social work, library science, physiology, anatomy, pharmacology). They run a clinic and an academic department, train medical students, residents, and physician associates, and perform research.

My research and teaching are about medical decision-making – specifically, decision analysis and the psychology of particular decisions made by physicians and patients. In informal settings, I also teach clinicians research methodology and the interpretation of research, codified as “evidence based medicine.”

A psychologist considering working at a medical school should read the analysis by Fang and Meyer (2003) that shows the increasing role of PhD scientists in medical schools, particularly in clinical departments. The study attributes this not only to our applicable research training, but also to the pressure on MD faculty to bring in clinical income, which limits the time they can devote to research. The study also discusses the possible status differences between MDs and PhDs, though it has no data on salaries.

The authors were surprised at the number of psychology PhDs in clinical departments. They note that psychological training in quantitative analysis and research methods can easily be transferred to clinical research, but still find it hard to account for. Therefore I want to give a sense of what this psychologist does – not only the content of my research and teaching, but also the relationship I have with my colleagues around those activities.

My psychology field is judgment and decision-making. My central role here in the medical school is to study how physicians should correctly make decisions versus how physicians and patients actually make decisions (e.g., Hamm & Smith, 1998). My projects have studied patient decision-making about particular economically important decisions concerning cervical, breast, and prostate cancer screening. How should the advantages and disadvantages of screening be communicated (McFall & Hamm, 2003)? How do patients perceive the communications, change their behavior, or react when they get a positive screening test result? To incorporate my abiding research interests, I include questions on people's perceptions of probabilities and other decision relevant information.

My identity as a psychologist is brought into play in many ways besides the research projects. As a teacher, I am a small group discussion leader in a second year medical student course on ethics that uses, in part, the Problem Based Learning approach. Socratic discussion of particular cases that present difficult dilemmas, such as "which of these imperfect patients should get the life saving transplant, and by what principles?" gives me an opportunity to engage students with the concepts of my field. I also run a 10-week summer research program involving medical students (and others) in clinical research, which examines questionnaires and other research methods, as well as statistics and research design. This is probably the only experience in clinical or behavioral research methods that they'll get during medical school.

A disadvantage for a psychologist teaching in a medical school is that you have no intellectual children; that is, people getting the same degree, focused on learning fundamentally the same field as you. In Europe the male dissertation advisor is called the "doctor father;" the psychologist in a medical school is more like an aunt or uncle. Among my many research assistants there have been a few psychology graduate students. I take pleasure as any of them move on, whether to medical school, physician associate school, jobs in epidemiology, or even clinical research in other (better paying) departments on campus.

My family medicine department offers a very collaborative role. Some of my colleagues are research amateurs, motivated by their interest in particular diseases; others are very methodologically sophisticated, but they have little time. To many of them, I represent all of psychology (including clinical, personality, educational), all of statistics, and all of research methodology. Gaps in my knowledge become their gaps. If I don't talk about it, they may not use it.

My most cited paper is one of these collaborations (Hamm, Hicks, & Bembien, 1996). Hicks had a passionate objection to the pharmaceutical sales force-driven use of antibiotics for patients with viral colds. The treatment doesn't work – in fact it promotes drug resistance – but doctors give antibiotics because they think patients want them. Our study asked patients with colds what they had wanted before they saw the doctor, then asked the doctor what the patient had wanted, what had been diagnosed, and what had been prescribed. Then we revisited the patients, asking how satisfied they were, whether they got what they wanted, how much time the doctor spent explaining the disease, and what prescription they would expect next time. We found that physicians don't guess patient expectations very accurately, patient expectations are rather malleable, patients are more satisfied when the physician explains things than when the physician prescribes antibiotics, and if the physician prescribes an antibiotic, the patient will expect one next time. As a result, I continue to be invited to review papers on physicians' treatment of colds. This shows that you don't know which application of your psychological methodology is going to gain you recognition.

A side effect of playing the helper role is that it draws attention from my central research interests. Recently I reviewed the promotion package of a psychologist in a department similar to mine. Her CV had an incredible variety of work, but where was the focus? Understanding and identifying with her situation, I read the papers and found the unifying theme, the common questions and methodological approach. This dispersion of focus is a disadvantage of the psychology career in the clinical medical school department, but it seems to come with the territory.

Given all this, I was surprised by a recent conversation with a friend who has been a full professor in a psychology department for decades. He wanted to shift to a job like mine! He spoke of the burdens of repeating the same courses for younger and younger students, the triviality of the behavior that is accessible in the psychology lab, as well as a lack of collaboration with colleagues. Maybe we should switch places for a sabbatical! I would probably be very happy to return home. But with luck, maybe he would want to stay and work in my department! Though not perfect, mine is still a pretty good academic life.

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## **From Psychology to Allied Health An Interdisciplinary Vision**

**By Tom Miller**

It was in the millennium year that an offer to join the School of Allied Health at the University of Connecticut materialized. I never contemplated such a move, but after a successful career as an

administrator, clinician, researcher, and educator, the surprising opportunity materialized. Allied health by definition involves a group of health-related professionals representing a variety of specialties including dietitians, medical laboratory scientists, diagnostic genetic scientists, cytotechnologists, physical therapists, respiratory therapists, occupational therapists, kinesiologists, and health promotion specialists, speech language pathologists and audiologists, among other professions.

I thought I had accomplished many of the milestones of a successful career in psychology. Since the onset of my career, I had a vision of interdisciplinary administration, research, clinical care and teaching. The opportunity to be involved in interdisciplinary international clinical and research exchanges – which took me everywhere from the Institute of psychiatry at the University of London, to the National Mental Health Research Centers in Russia and Armenia – produced a remarkable series of publications reflecting international and interdisciplinary clinical research experiences.

There were many positive variables to address in exploring this pathway, one of which was the emphasis at NIH on interdisciplinary research and science. Psychology and the behavioral sciences could play a critical role in such an emphasis. In the year 2000, there was an initiative to fund collaborative efforts, and one that immediately caught my eye was the Center for Health HIV Intervention and Prevention on the campus of the University of Connecticut. The focus of this effort was to provide an interdisciplinary experience within a center consisting of several professionals representing a variety of allied health disciplines. The core and leadership in this center promote mentorship and collegial enterprise among the students, faculty, and administrators, and when the director of the center extended an invitation to join this esteemed group of colleagues, I knew that interdisciplinary clinical and research endeavors had a vision and a home on this campus, one where I could offer the wealth of knowledge gained from two decades in a university college of medicine and department of psychology, where I worked closely with physicians, nurses, dentists, pharmacists, and allied health professionals.

There were many intriguing aspects to joining the school of allied health, the most significant of which was the potential for collegial sharing in science, teaching, research, and clinical practice. This sharing has, in many cases, advanced to the level of enterprise. Efforts to adopt the multidisciplinary approach have been a significant contribution to the body of knowledge that comprises the allied health professions. Each discipline brings to the table unique contributions and pathways to sound research and clinical efforts. Much can be learned from the arrangement offered at the school of allied health. All health related professions should consider a place under the multidisciplinary umbrella of allied health.

The opportunity to work in a university community and school of allied health that has captured and cultivated interdisciplinary sharing and exchange of ideas, theory, research, and practice has provided the chance to touch the careers of several students, emerging faculty, and colleagues in the health related professions and allowed for much interdisciplinary collaboration.