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## INTERVENTION COMPETENCY

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"The intervention competency is conceptualized as activities that promote, restore, sustain, and/or enhance positive functioning and a sense of well-being in clients through preventive, developmental, and/or remedial services" (McHolland, chap. 21, p. 163–164). The conferees at the 1986–1987 midwinter meeting of the National Council of Schools of Professional Psychology (NCSPP), the Mission Bay conference, had little difficulty agreeing that intervention should be a competency area in the curricula in professional programs in psychology. It is significant that intervention, not psychotherapy, was the designated curriculum competency area. This advance in curriculum conceptualization represented the recognition that intervention is an increasingly broad, complex area that includes more than the psychotherapies. The Mission Bay conferees explicitly directed that intervention should include theory and technique related to systems (couples, families, groups, and organizations) as well as to individuals (Bourg et al., 1987). As is implicit in all the competencies, the emphasis in intervention on demonstration of skills necessitates an experiential learning and evaluation component, not only classroom lecture and paper-and-pencil examinations.

The conceptualization of intervention developed at Mission Bay was reaffirmed and expanded at the NCSPP 1989–1990 midwinter meeting, the San Antonio core-curriculum conference. In addition to the Mission Bay formulation, the San Antonio conferees resolved that:

*The intervention competency relies especially on the following knowledge base: theories of individual and systems change, including the functioning and change of sociopolitical structures; theories and strategies of intervention; methods of evaluation and quality assurance; professional ethical principles and standards of practice. Along with the information derived from psychotherapy research, the knowledge and methods appropriate to the understanding of self and the self–other relationship, as well as to the significance of power and authority, are particularly relevant. (McHolland, chap. 21, p. 164)*

We believe that the future of all psychological intervention depends on outcome effectiveness, reasonable accessibility, and cost-effectiveness. Because no single model or theory is effective for all persons and practitioners, we propose a systematic, eclectic approach to learning and practice. Our formulation of the intervention competency includes both established and innovative components.

### Individual Intervention

Psychotherapy (or counseling) for individuals is an essential part of the core. The psychotherapy core component should be rooted in an eclectic model, presenting major theoretical approaches such as psychodynamic, interpersonal, systemic, experiential, and cognitive-behavioral as positive viewpoints, all of which contribute to understanding clients and to change. Advanced study or special proficiencies are related to, but not an intrinsic part of, the core. Areas such as health psychology, addictions, women's issues, and forensic applications may be taught from either an eclectic or a specific theoretical orientation.

The individual psychotherapy core might reasonably be built on a human problem-resolution model. In this formulation, the unifying concepts are a respect for empirical research findings related to intervention and an attempt to apply such findings, attending to strategies, techniques, and outcome more than to theory. The Mission Bay vision for all competencies is relevant here: (a) the importance of the scientific component, (b) the value system of scientific self-criticism, and (c) the recognition of the limitations of each approach.

Most individual psychotherapy models are based on models developed for long-term treatment. We believe that long-term treatment approaches are not consistent with public and private utilization patterns, client satisfaction, or outcome. Therefore, we propose that instruction in long-term approaches be reserved for a special proficiency level. As such, they would not be seen as the usual approach for the majority of clients but rather the exception. Focused, more active psychotherapeutic service strategies should be taught at the core level.

### Systems Intervention

For many years, individual psychotherapy and assessment (a battery approach) have been the primary activities of clinical psychology. A NCSPP curriculum survey (Kopplin, 1986) indicated that 45% of the responding schools did not offer, much less require, a course in group, couples, or family psychotherapy. The Mission Bay conference resolution supporting the inclusion of couples, families, groups, and organizations in the intervention area presented a challenge in curricular reform (Bourg et al., 1987). Since that conference, it is our impression that many programs have begun to include systems larger than the dyad in the intervention curriculum.

The systems approach is an essential part of the intervention core. Clients should be viewed as embedded in a pluralistic, multicultural context. The curriculum should provide students with a base from which to approach couples, single parents, families or units of significant others, groups, organizations, communities, and international configurations. Programs may develop special proficiencies in couples and families or in organizational psychology, for example, based on the same generic or core curriculum

and later may develop specialization programs in these areas. This conceptualization has profound implications for curricular reform.

### Broadening the Intervention Core

Programmatic or systematic approaches to intervention should be included in the core. Psychotherapy usually involves individualized service planning (a basic knowledge and skill). Programmatic approaches extend this basic planning ability to the design of regularized service delivery systems and programs. Examples include pain-reduction programs, eating-disorder intervention programs, organizational team-building programs, and so forth. These powerful intervention programs have applications in many contexts. They lend themselves to the use of nondoctoral personnel and contractually packaged programs. In a general contractor role, instead of in the historic employee role in psychiatric settings, the psychologist must apply the management competencies proposed by Bent, Schindler, and Dobbins (chap. 16). It is anticipated that future training in intervention will prepare the psychologist to be the most well-rounded and fully equipped human service provider in society.

The intervention curriculum should include biomedical technology and psychopharmacological components. Psychologists should be expected to have a basic understanding of medical technology such as biofeedback, CAT (computerized axial tomography) scan, MRI (magnetic resonance imaging), EMG (electromyography), EEG (electroencephalography), PET (positron emission tomography), and the ever-increasing armamentarium of diagnostic and treatment modalities using biomedical technology.

A fundamental appreciation of psychopharmacotherapy is now taught in many programs; all programs should include this component. Some psychologists are advocating for limited prescription rights and for training in the administration of pharmacological agents. Demonstration programs have been proposed. This could be an option for a special proficiency area, even though it is fraught with practical and political problems.

The intervention core should include training in developing productive relationships with community helping networks. Collegial planning with related professionals, evaluation of the effectiveness in meeting the needs of referring parties, and referral networking are fundamental to modern practice.

A computer component is suggested as a foundation requirement. Familiarity with computer-assisted information retrieval, including suggested psychotherapeutic methods, manualization of psychotherapy approaches, computer-assisted therapy, and computer assessment techniques, will be increasingly important in the intervention area.

It is important to broaden the concept of client or patient. We prefer client to patient because client implies participation, choice, and coactivity on the part of the service provider and the service recipient in a way that is consistent with an emphasis on context and the systems approach. A client may be an individual, a group, an organization—any service partner. One may use the term *patient* in certain situations, for example, in explicitly medical circumstances, but it is difficult to think of a marriage or an organization as a patient.

The introductory core should introduce the concept of change in terms of well-being. Perhaps the national image that best suits psychology as a profession is helping "the worried well" and building wellness or effectiveness in people's lives. Within this framework, client rather than patient is more compatible with perspectives emphasizing well-

ness, human effectiveness, and development. The student should learn to assume the role of human resources expert, able to deal with current and emerging configurations of the human dilemma. We must appeal beyond our well-established territory in the diagnosis and illness terrain and not use only concepts from psychopathology.

Prevention is related to wellness. We contend that prevention methods of intervention should assume a central role in future curricula. The realm of the psychologist should include normal everyday problems, developmental issues, and conflicts inherent in life situations in addition to or in place of work in the illness context. The prevention approach shows particular promise when there is an emphasis on the development of effective life-styles that relate to stress reduction, enhanced productivity, and the prevention of psychological and physical disability.

The other five competency areas (i.e., relationship, assessment, research and evaluation, consultation and education, and management and supervision) relate to and integrate with the intervention competency. The relationship competency, in particular, is a central and critical component of intervention. Focused, early teaching of the relationship competency allows early and coherent integration with the intervention competency.

There is a consensus that differing intervention methods and orientations may lead to client improvement based on spontaneous remission, common therapeutic factors, special techniques, and placebo effects (Lambert, 1986). Spontaneous remission depends in large part on the context of the client's life. A systems intervention may enhance life variables, for example, involving a family in therapy or developing a surrogate family. The common therapeutic factors should be greatly enhanced by special attention given to the interpersonal relationship competency, critical to forming and maintaining the positive therapeutic transaction. Special techniques should build a reasonable base, especially an introduction to group and family approaches, and teach a limited, varied number of psychotherapy techniques from a transtheoretical perspective. The placebo effect may be enhanced by proper therapy role induction, by education, and by more careful attention to client expectancy variables through reasonable goal-attainment "contracting."

In summary, a comprehensive and broad vision of the intervention competency explicitly should include the following:

1. A respect for the positive aspects of all major approaches, which should reflect an openness to varied viewpoints and methods.
2. An appreciation of a systematic, eclectic approach.
3. The learning of an array of varied, specific psychotherapeutic techniques from a transtheoretical viewpoint, including individual psychotherapy and interventions with systems such as couples, families, groups, and organizations.
4. A problem-resolution model.
5. A focused service strategy at the basic level and long-term approaches at the special proficiency level.
6. More use of the programmatic approach.
7. An understanding of basic biomedical technology.
8. Inclusion of a foundation in psychopharmacotherapy.
9. Mutual planning skills with community helping networks.
10. An introduction to computer information retrieval.
11. A broad view of the client that includes serving the client in many locations.
12. A human effectiveness perspective as well as an illness or a diagnostic model.

13. A prevention approach coupled with an effective life-style component.
14. Fundamental reliance on and training in establishing a positive therapeutic relationship.
15. Sensitivity to context and to diversity, especially multicultural and gender issues.

## Pedagogy

Each program should establish the intervention core curriculum consistent with its (a) definition of professional psychology, (b) special proficiency areas, (c) resources, (d) methods of evaluating competency, and (e) career patterns of graduates.

Questions to be answered include the following: Where, when, how, and by whom should the core be taught? What resources should be used? We have no simple answers. Because each program has its own array of resources and emphases, particular approaches to the intervention core, quite reasonably, should vary. Although a generally defined foundation is essential, each program should teach it in a manner that is consistent with its goals and its training model.

The intervention core curriculum necessarily includes fieldwork and simulated laboratory work under supervision. Increasingly, supervised practice should occur in program-sponsored and controlled psychology service systems (centers) where training can be more specific and can be controlled by the program itself. Development of these training resources is very important in meeting the specific curriculum requirements.

We believe that programs should move to year-round curricula, that include a minimum of 1,200 hours of supervised experience. These hours should total about 2 days a week for a 40-week practicum in a practice placement. In addition, the first-year skill and knowledge development, with laboratory hands-on training, should include technical learning using video, manualization, simulated situations, and small-group methods. The internship should follow extensive course work often as an extension of the curriculum itself or as a closely coordinated experience with regional, cooperative internship programs that have a continuing relation with the predoctoral program.

We suggest a reduction in formal, academic, lecture-format teaching, so that single content or course areas can extend across quarters, semesters, or trimesters. Areas to be taught, particularly in competency areas, should be organized in logical clusters early in the curriculum. Workshop formats, practice tutorial methods, and independent learning should be used more extensively. Examples of methods that make teaching more effective and less labor intensive include more technical support for teaching, such as computer-assisted programs for testing and for planning skills; observation of actual practice; immediate feedback; and supervision.

Based on a general curriculum-design format, the model presented in Table 1 is one approach to teaching the intervention competency core. Each teaching sequence should be about 10 class meetings (25–30 hr) plus laboratory or practicum experience. Starting at the second-year level and continuing at the third-year level, special areas of proficiency or focus should be offered. These areas may contribute to a generalist application or may narrowly relate to special applications.

**Table 1**  
**One Approach to Teaching the Intervention Competency Core**

Year/quarter	Teaching sequence
1	
Fall	Introduction to intervention
Winter	Basic individual psychotherapy 1
Spring	Systems intervention 1: couples and family
Summer	Systems intervention 2: groups and organizations
2	
Fall	Psychopharmacotherapy, biomedical and computer technology, physical interventions
Winter	Basic individual psychotherapy 2
Spring	Programmatic approaches
Summer	Intervention: special proficiency level

*Note.* Basic laboratory and intensive observation and simulation methods should be incorporated throughout the first year. In the second year, the student is in a supervised practice field placement for two days per week.

## Conclusion

This perspective on intervention goes far beyond traditional formulations. Once limited to the psychotherapy of individuals, the focus of intervention has been broadened to include the entire array of human systems. Initially, intervention was seen as a psychotherapeutic process designed to cure the mentally ill. Now, more globally defined, intervention is the advancement and the support of positive development or change and the enhancement of effectiveness. Every less-than-productive human situation or enterprise could profit from positive psychological intervention.

Psychologists of the future need broad-based, multidimensional intervention skills. To impart this new, comprehensive vision of intervention, programs need to initiate curricular reform. The psychologist of the future must be able to "pull the logs out of the stream" and in addition be able to move upstream to prevent a log jam from occurring. It is our belief that the training inherent in this expanded view of the intervention competency will enable the psychologist of the future to do both.