

APA Division 38 - Tempe Summit Report
Application of the Competency Model to Clinical Health Psychology

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A. History of training in clinical health psychology

The specialty of clinical health psychology applies scientific knowledge of the interrelationships among behavioral, emotional, cognitive, social and biological components in health and disease to the promotion and maintenance of health; the prevention, treatment and rehabilitation of illness and disability; and the improvement of the health care system. The distinct focus of clinical health psychology is on physical health problems. The specialty is dedicated to the development of knowledge regarding the interface between behavior and health, and to the delivery of high quality services based on that knowledge to individuals, families, and health care systems. (American Psychological Association [APA], 1997)

This definition was archived by the APA Council of Representatives upon formal recognition of clinical health psychology as a specialty in 1997. However nearly 30 years prior to that event, William Schofield issued the seminal report titled *The Role of Psychology in the Delivery of Health Services* (Schofield, 1969). In 1978, two important professional organizations were founded, the Society of Behavioral Medicine and the APA Division of Health Psychology. Soon thereafter surveys and treatises on relevant education and available training were published (Belar, 1980; Belar, Wilson & Hughes, 1982; Gentry, Street, Masur & Asken, 1981; Belar & Siegel, 1983), and the Arden House National Working Conference on Education and Training in Health Psychology articulated a comprehensive model that has considerable support to this day. (Stone, 1983)

The Arden House Conference endorsed two training options: scientist and scientist-practitioner. Conference participants stated that all education and training should focus on diversity; integrate theory, research, and practice; emphasize research methodologies and skills in interdisciplinary collaboration; provide instruction in ethical, legal and professional issues; provide instruction in health policy and health care organization; and provide for computer literacy. Programs would need breadth and depth in resources, and not be limited to one theoretical perspective or methodology, although a biopsychosocial model was fundamental. The need for diversity among faculty and students was also highlighted.

In terms of content, doctoral education and training was to include general psychology core requirements as well as specific core requirements in health psychology such as social bases of health and disease, biological bases of health and disease, health policy and organization, health assessment and intervention; health research methods and evaluation research. Courses such as child health, behavioral genetics, epidemiology, public health, anatomy and pathophysiology were seen as critical, as was actual research experience in applied health care settings with appropriate faculty role models.

Practitioners were to receive additional training in assessment related to health diagnosis; social and family systems related to health; personality/psychopathology as related to health problems; interventions relevant to health problems; medical knowledge; consultation; interdisciplinary collaboration; health care delivery systems; and professional, ethical, and legal issues related to health care. Also recommended was a full year internship in an organized, interdisciplinary health service training program engaged in both psychological and physical health care where psychologists were appointed to the professional staff and where the mentors were health psychologists themselves.

The Arden House Conference also recommended that APA move toward the accreditation of doctoral programs at the generic level of professional psychology only, with accreditation of specialties to begin at the postdoctoral level. Participants recommended the establishment of a council of health psychology training programs to designate programs meeting acceptable standards, and called for the development of mechanisms for board certification of practitioners. In 1984 Joseph Matarazzo incorporated the American Board of Health Psychology, which received recognition by the American Board of Professional Psychology (ABPP) in 1990, and was a fully affiliated board of ABPP by 1993. (Belar & Jeffrey, 1995). In 1998 the board renamed itself the American Board of Clinical Health Psychology to maintain consistency with its participation in the petition for recognition as a specialty by the APA.

The 2004 petition by Division 38 for continued recognition of clinical health psychology as a specialty maintains the thrust of the Arden House recommendations, with an even more integrated approach. The foundational knowledge base is described as biological, cognitive-affective, social and psychological bases of health and disease as integrated with knowledge of biological, cognitive-affective, social and psychological bases of behavior. The more recently developed areas of psychoneuroimmunology and

neuroendocrinology receive attention in addition to the previously noted needs in anatomy and physiology, genetics, pharmacology and psychophysiology. There is also increased emphasis on health beliefs; spiritual and religious dimensions; a broad range of human diversity; and disease-specific and quality of life measures.

In 2006 there were 68 doctoral programs in clinical, counseling or school psychology offering training in clinical health psychology (APA, 2006). There were also 201 internships with major rotations, 381 with minor rotations, and 51 postdoctoral programs (APPIC, 2006). By 2007 there were five APA accredited postdoctoral programs in the specialty of clinical health psychology, and the APA had approved policy to expand the scope of accreditation of doctoral programs in “developed practice areas.”

B. Process leading to this document

In Fall 2005 the Board of Directors of Division 38 (Health Psychology) of the American Psychological Association began discussion of the possibility of forming a task force that would be charged with planning a conference to discuss issues pertaining to education and training in clinical health psychology and to potentially determine the level of interest in reconstituting the then inactive Council of Clinical Health Psychology Training Directors. As noted earlier, there was concern that, given the enormous growth of the field since the Arden House conference in 1983, issues of education and training needed specific contemporary focus and attention and this also seemed an opportune time to reactivate the Training Council. In November 2005 the task force was formed with Christopher France and Kevin Masters serving as co-chairs. The goals of the conference would be to 1) bring interested parties together to begin a dialog on issues of curriculum and training and 2) explore the possibility of establishing a standing Council of Clinical Health Psychology Training Directors. Assuming sufficient interest this initial conference would be followed by a second conference that would continue to explore the issues among any interested parties and potentially form anew a standing Training Council with a defined organizational structure, by-laws, and elected representatives. In December, 2005 the Division 38 Board authorized work to begin on planning the conference and noted that they would consider a request for funding for the conference.

During January 2006 Dr. France worked to develop a list of doctoral programs in clinical psychology that were identified as having significant health psychology components, and in February 2006 an e-mail was sent to representatives of these programs. The e-mail briefly enumerated various issues in clinical health psychology and inquired regarding: 1) Your level of interest in these issues (0 = no interest to 10 = extremely interested); and, 2) Your likelihood of attending a one or two day summit to discuss these issues with your colleagues (0 = will not attend to 10 = certainly will attend). A request for additional comments was also presented. Twenty-seven (29%) programs responded and the mean response to question #1 was 7.00 ($SD = 3.1$; $Mdn = 8.0$) and to question #2 was 6.3 ($SD = 3.6$; $Mdn = 8.0$). This suggested sufficient interest to pursue the conference. At this point it was also determined that it would be desirable to include a liaison with the Division 38 Education and Training Committee in the planning process. Dr. Sonia Suchday agreed to serve in this position.

A planning meeting of the Task Force (France, Masters, Suchday) took place in Syracuse, NY on July 7-8, 2006. At this meeting a proposal was written that provided an outline for the conference and a budget to be presented to the full Division 38 Board of Directors during the Annual Convention of the American Psychological Association in New Orleans, August, 2006. Dr. Suchday was present in New Orleans to address comments and questions concerning the proposal. The Board undertook the matter with serious and thoughtful deliberation and in a subsequent electronic vote in September 2006 unanimously agreed to provide funding and support for the development and conduct of an "Executive Summit" to begin examination of these important training issues. To reduce the cost, it was recommended that the summit be held in conjunction with the Mid-Winter Meeting of the Division 38 Board which would occur in Tempe, AZ on March 2-3. Accordingly, the Executive Summit was scheduled for March 1-2, 2007.

One issue remained, namely, who should attend the Summit. The Board requested that attendees consist of a group that would be diverse along the lines of race, ethnicity, gender, and geographic location and would include interested parties representing private practice, academic medical centers, military psychology, major clinical psychology doctoral programs with health emphasis, individuals primarily associated with health psychology research, and a representative of counseling health psychology. To facilitate this process the Task Force requested nominations from the Division 38 Board. Subsequently 20 individuals (the budget limit) were selected and an e-mail invitation to these individuals was sent in November 2006. Of the 20 individuals invited to the meeting only one declined (though he clearly desired to attend, a scheduling conflict with an APA accreditation site visit precluded his involvement) and two suggested that there was a better qualified individual at their institution (subsequently letters were sent to these individuals and both attended the conference).

As noted earlier, preparation for the summit was guided by the cube model for competency development elaborated by Rodolfa et al. (2005) and by the procedures and content specified in the "Assessment of competency benchmarks work group: A developmental model for the defining and measuring competence in professional psychology; February 2007" developed by the Assessment of Competency Benchmarks Work Group convened by the APA Board of Educational Affairs in collaboration with the Council of Chairs of Training Councils. A call then went out to all summit participants asking them to: 1) nominate readings that they deemed useful in preparation for the conference and, 2) submit information regarding their particular training program that could be compiled into a reference notebook to be distributed to all summit attendees. Weekly planning conference calls took place during January-February, 2007 and the roster of attendees was divided into three sub-groups each representing two functional competency domains as articulated in the benchmarks document. The sub-groups were also charged with consideration of the six foundational competency domains (reflective practice self-assessment, scientific knowledge-methods, relationships, ethical-legal standards-policy, individual-cultural diversity, and interdisciplinary systems) as they relate to the functional competencies; forming a 2 X 6 matrix. Possible individuals to chair each subgroup were suggested during conference calls and all nominees agreed

to serve as chair. Group 1 was assigned the assessment-diagnosis-case conceptualization and intervention functional competencies. Kevin Larkin agreed to chair this group and members were Helen Coons, Beverly Thorn, Nathan Perry, Steve Tovian, Hector Myers, and Marilyn Stern. Group 2 tackled consultation and research-evaluation competencies and was chaired by Timothy Smith. Members included Patrice Saab, Thomas Kamarck, Chris France, Sonia Suchday, and Kevin Masters. Group 3 was chaired by Elizabeth Klonoff and assigned the competencies of supervision-teaching and management-administration. Group members were Cynthia Belar, Suzanne Bennett-Johnson, Larry James, Robert Kerns, Mary Davis, and Jesse Milby. Prior to the summit, sub-group leaders contacted the members of their respective groups to begin a dialogue with them and to solicit nominations of particular articles that may be appropriate for each sub-group's purposes. These contacts occurred among all subgroups over the next few weeks leading up to the conference and several readings were subsequently included in materials sent to conference attendees in advance of the meeting (see Appendix for list of readings).

The summit occurred as scheduled on March 1-2, 2007 in Tempe, AZ. The meeting opened with remarks pertaining to the process of organizing the meeting and with discussion of the competency matrix model that would guide sub-group discussions. Next, Cynthia Belar provided an overview of the history of training in clinical health psychology. Subsequently, work and discussion began in each of the sub-groups. Each was charged with discussing the specific competencies assigned to their group with reference to a well-trained, entry-level clinical health psychologist. They were reminded that the goal was not to suggest a specific curriculum, but rather to provide a broad and general outline as to how functional and foundational competencies might be achieved in the context of the specialty of clinical health psychology. The intended product of the summit was noted to be the development of a document to be presented for discussion at a subsequent, larger meeting of all interested stakeholders. Each group was expected to produce a two to five page written summary that articulated the competencies within their assigned cells of the competency matrix along with corresponding methods that would augment the likelihood of their achievement. The subgroups met for three hours on Thursday afternoon before reconvening after dinner to present their results. Following the evening discussion among the entire group it was suggested that additional time be set aside on Friday for the subgroups to meet again, revise their documents, and incorporate feedback from the other groups. The product of these discussions follows.

C. Purpose for the summit: Articulating the competencies

As previously mentioned, in May of 1983, APA Division 38 (Health Psychology) held a National Working Conference on Education and Training in Health Psychology at Arden House in Harriman, New York to provide a comprehensive assessment of "...the skills and knowledge required to function effectively in the various research, professional, and administrative health settings and to formulate guidelines and recommended standards for graduate, postgraduate, and continuing educational levels of training in health psychology." (Weiss, 1983, "Planning the Conference" p.19).

Given the continuing evolution of science and practice of psychology, medicine, and other health professions, the standards recommended at Arden House may or may not adequately fulfill the needs of current trainees. To further examine this issue, the Board of Directors of APA Division 38 sponsored a summit with a specific focus on revisiting the standards of graduate curriculum and training in clinical health psychology. In line with an increasing emphasis on defining expected competencies in the education and practice of psychology, it was agreed that summit participants would focus their efforts on describing the distinct competencies expected of those who complete graduate training in the specialty of clinical health psychology. Summit participants were encouraged to consider the *foundational* and *functional* competencies expected of a well-trained, entry level clinical health psychologist.

The summit's approach to defining competencies was borrowed from the Assessment of Competency Benchmarks Work Group, which was convened by the APA Board of Educational Affairs in collaboration with the Chairs of Training Councils to "...develop a set of organized and sequential competency benchmarks." In February of 2007, the Assessment of Competency Benchmarks Work Group published an update on their efforts to outline the core competency domains of professional psychology. This document was organized around the Cube model of core competencies in professional psychology as defined by Rodolfa and colleagues (2005). Specifically, the Cube model represents the core competency domains of professional psychology as a three-dimensional matrix. One dimension of the matrix is defined by six foundational competencies (i.e., reflective practice self-assessment, scientific knowledge and methods, relationships, individual-cultural diversity, ethical-legal standards-policy, diversity, and interdisciplinary systems), which include the knowledge, skills, attitudes and values that underlie the functions a psychologist is expected to carry out. A second dimension is defined by the functional competencies (i.e., assessment-diagnosis-case conceptualization, intervention, consultation, research/evaluation, supervision-teaching, management-administration), which include the major activities that a psychologist is expected to perform. The third dimension of the Cube model represents the developmental process and expected changes in competency across stages of training (i.e., doctoral, post-doctoral, advanced post-doctoral, lifelong learning). Because the Division 38 summit was conceived as a focused examination of the competencies expected of a well-trained clinical health psychologist who was just prepared for entry into the profession, summit participants were not asked to address this third dimension. Thus, the primary focus was on education at the doctoral level.

D. Foundational competencies in clinical health psychology

One common definition of competence in professional practice is "the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served." (Epstein & Hundert, 2002, pg. 243). Professional competencies are further conceptualized as having foundational elements and functional elements. Foundational competencies, such as knowledge, attitudes, and values, serve as

the underpinning for functional competencies, such as the skills associated with assessment, intervention, consultation, and research expected of a professional.

The specialty of clinical health psychology shares foundational competencies with those articulated in the Competency Benchmarks Document (2007). Furthermore, clinical health psychology has foundational competencies unique to clinical health psychology, but common across functional domains.

D.1. Foundational competencies in common with professional/scientific psychology

The foundational competencies articulated in the Competency Benchmarks Document (2007) are applicable to all health service providers in professional psychology, including clinical health psychology. The common competencies are the following: 1) *Reflective Practice Self-Assessment*, which includes practicing within the boundaries of one's competences, being committed to lifelong learning and scholarship, engaging in critical thinking, and being dedicated to the development of the profession; 2) *Scientific Knowledge and Methods*, which includes a respect for scientifically derived knowledge, the ability to understand research methods, data collection techniques and data analyses, and the capacity to appropriately evaluate research products. This area also includes specific knowledge bases in the biological and cognitive-affective foundations of behavior, as well as lifespan human development; 3) *Relationships*, which involves the capacity to have meaningful and productive professional relationships with individuals, groups, and communities; 4) *Individual-cultural Diversity*, which includes awareness and sensitivity when working with individuals, groups and communities with diverse cultural backgrounds and unique personal characteristics; 5) *Ethical-legal Standards-Policy*, which involves the appropriate application of ethical standards as well as an awareness of legal issues associated with professional activities and advocacy for the profession; and 6) *Interdisciplinary Systems*, which involves identification and appropriate professional involvement with one's colleagues and peers, including the ability to interact knowledgeably with professionals in related fields.

It is important to note that clinical health psychology also has foundational competencies unique to the specialty. These competencies are seen as common across functional domains, and like the general foundational competencies, the specialty foundational competencies are integrated into each of the functional competencies.

D.2. Foundational competencies unique to clinical health psychology, but common across functional domains

The following are the foundational competencies unique to clinical health psychology: 1) Engage in reflective self-assessment regarding the dynamic knowledge base and skill set necessary for working with individuals and families with physical health concerns, with an awareness of their place in a larger social and relational context and health systems; 2) Access and evaluate the best available biopsychosocial evidence relevant to the practice of clinical health psychology, taking into consideration patient gender, ethnicity, culture, values, preferences, and other relevant individual and culturally based differences; 3)

Demonstrate an awareness of the unique nature of interdisciplinary collaboration in health care, and the importance of patient-practitioner relationships; 4) Understand the particular ethical-legal standards involved in the healthcare system.

E. Functional competencies in clinical health psychology

E.1. Assessment competencies

E.1.1. Knowledge based competencies:

The entry level clinical health psychologist will have knowledge of the various:

- a. biological assessment strategies relevant to individuals and systems
- b. psychological assessment strategies relevant to individuals and systems
- c. social-environmental assessment strategies relevant to individuals and systems

E.1.2. Functional competencies:

The entry level clinical health psychologist will be able to:

- a. independently evaluate the question/problem and appropriate level of analysis, and in so doing, select and administer biopsychosocial and cognitive assessment tools appropriate for the patient's physical illness, injury, or disability for the purpose of developing treatment and rehabilitative services.
- b. conduct a comprehensive biopsychosocial interview and evaluate objective (relevant) biological and psychosocial findings related to physical health or illness/injury/disability.
- c. assess biopsychosocial risk factors for the development of physical illness, injury, or disability.
- d. assess environmental factors that facilitate or inhibit patient knowledge, values, attitudes, and/or behaviors affecting health functioning and health care utilization.
- e. assess biopsychosocial factors affecting adherence to recommendations for medical and psychological care.
- f. assess the biopsychosocial impact of medical procedures (including screening, diagnostic and intervention/prevention procedures).
- g. demonstrate an understanding of ethical and legal ramifications of biopsychosocial assessment strategies in addressing health and healthcare issues.
- h. demonstrate the ability to appropriately access, evaluate, and utilize information to assist in assessment using new and emerging health technologies.

E.2. Intervention competencies

E.2.1. Knowledge based competencies:

The entry level clinical health psychologist will have knowledge of:

- a. pathophysiology of disease and extant biomedical treatments, and their implications for the delivery of biopsychosocial treatments.
- b. psychological factors associated with health behavior, illness, and disease, and their implications for the delivery of biopsychosocial treatments.
- c. social-environmental factors associated with health behavior, illness, and disease, and their implications for the delivery of biopsychosocial treatments.

E.2.2. Functional competencies:

Through accessing and evaluating the best available biopsychosocial evidence and taking into account patient gender, ethnicity, culture, values, and preferences, the entry level clinical health psychologist will be able to:

- a. implement empirically supported treatment interventions appropriate to the target population.
- b. implement empirically supported health promotion and prevention interventions.
- c. conduct empirically supported interventions in the context of an interdisciplinary team.
- d. independently evaluate, and in so doing, select and administer biopsychosocial and cognitive assessment tools appropriate for the patient's physical illness, injury, or disability for the purpose of monitoring and evaluating the process and outcomes of treatment and rehabilitative services, including their potential risk for harm.
- e. demonstrate an understanding of ethical and legal ramifications of biopsychosocial intervention strategies in addressing health and healthcare issues.
- f. demonstrate the ability to appropriately access, evaluate, and utilize information in designing and implementing treatment, health promotion, and prevention interventions using new and emerging health technologies.

E.3. Consultation competencies

E.3.1. Knowledge based competencies:

The entry level clinical health psychologist will have knowledge of:

- a. professional roles and expectations within the context of medical consultation, including limits of expertise and skills.
- b. relevant scientific literatures as they bear on medical consultation/liaison.
- c. operating policies and procedures in different medical environments, including medical clinics, hospitals, and public health and policy settings.

E.3.2. Functional competencies:

The entry level clinical health psychologist will be able to:

- a. conceptualize referral questions that bear on human behavior (including an understanding of the client's role).
- b. communicate about and cultivate mutual understandings about problems among individuals from diverse disciplines.
- c. translate and communicate relevant scientific findings as they bear on the medical consultation/liaison questions.

E.4. Research competencies

Notwithstanding the fact that the individual is often the primary unit of analysis, the clinical health psychologist's research skills must reflect the multilevel and interdisciplinary nature of the profession.

E.4.1. Knowledge based competencies:

The entry level clinical health psychologist will have knowledge of:

- a. dynamic interactions between populations and contextual variations (age, gender, ethnicity, culture, etc.) on health behavior and health outcomes.
- b. mechanistic and mediational pathways between contextual, psychosocial, and biological phenomena as they relate to health promotion, illness prevention, and disease progression.
- c. scientific foundations and methods of psychology and allied health disciplines (e.g., epidemiology, physiology).
- d. strengths and potential pitfalls of role relationships that characterize interdisciplinary collaborative research
- e. legal/ethical issues relating to interdisciplinary research

E.4.2. Functional competencies:

The entry level clinical health psychologist will be able to:

- a. apply diverse methodologies to address contextual, psychosocial, and biological processes as they relate to health promotion, illness prevention, and disease progression.
- b. select, apply, and interpret data analytic strategies that are best suited to the diverse research questions and levels of analysis characteristic of health psychology.
- c. accurately and efficiently communicate research findings in a manner that is consistent with the highest standards within the profession.

E.5. Supervision/training competencies

The supervision and teaching role of a clinical health psychologist requires attention to the interdisciplinary nature of the health care setting. These different health care professions have different roles, identities, standards, and health-related beliefs.

E.5.1. Knowledge based competencies:

The entry level clinical health psychologist will have knowledge of:

- a. the type of students/trainees operating within a health care setting
- b. the role of other health care professionals (e.g., medical students, nurses, social workers) in the treatment of an individual and/or within an interdisciplinary health care team
- c. the skills and competencies required of other health professionals who wish to do research in health care settings

E.5.2. Functional competencies:

The entry level clinical health psychologist will be able to:

- a. be proactive and anticipate the kinds and scope of problems and issues that might be encountered
- b. deal effectively with the kinds of issues and challenges that may be unique to working in health care settings (e.g., dealing with the aftermath of surgical procedures, death and dying, infection control procedures)
- c. utilize informatics and other technology-based methods to obtain both the basics and the latest information about a disease being addressed
- d. demonstrate an awareness of and appreciation for the unique knowledge base, skill set, role in the health care team, limitations of, and boundaries associated with the array of professions that provide services to the population being treated
- e. train students to assert their professional autonomy and identity
- f. provide supervision that takes into account individual and cultural differences of both consumers and other members of the health care team
- g. encourage behavior that appropriately respects the professional autonomy of other professions
- h. provide effective instruction and supervision in psychology both to psychology trainees and across disciplines and across levels of training
- i. provide effective instruction and supervise the conduct of health-related research across disciplines

E.6. Management/administration competencies

E.6.1. Knowledge based competencies:

The entry level clinical health psychologist will have knowledge of:

- a. appropriate methods to develop a group or individual practice
- b. the legal, economic, logistical, and practical aspects of day-to-day functioning within a group or individual practice, or within a research program environment
- c. appropriate methods and procedures to develop a program of research

E.6.2. Functional Competencies:

The entry level clinical health psychologist will be able to:

- a. conduct the “business” of health psychology practice and research management including: coding, electronic records, and billing; demonstrating an awareness of the skills required to be able to recruit, hire, and retain personnel to work for the psychologist, including writing position descriptions and performance evaluations; and developing policy and procedure manuals
- b. develop clinical health psychology services and to evaluate their effectiveness and their quality
- c. provide leadership within an interdisciplinary team or organization (e.g., demonstrate competence in recognizing, seeking consultation about and, when appropriate, managing the ethical dilemmas in the context of a interdisciplinary professional setting)

E. Concluding statement

The current document articulates the best efforts of the Tempe Summit participants to apply the competency model to clinical health psychology. It should also be noted that this summit was viewed as an initial step in a process of reexamining the expected competencies, and by no means was it intended to be a final product nor a series of recommendations. Accordingly, the current document is intended as a work in progress open to revision in response to public comment and further review by relevant constituencies.

Appendix

Readings Assigned for Tempe Executive Summit:

1. Petition for the Recognition of a Specialty in Professional Psychology. APA
2. Baum, A., Perry, N.W. Jr., & Tarbell, S. (2004). The development of psychology as a health science. In R.G. Frank, A. Baum, & J.L. Wallander (Eds.). *Handbook of clinical health psychology* (pp. 9-28). APA: Washington, DC.
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