INTRODUCTION

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Chapter

The History, Politics, and Social Environment of Clinical Psychology

This chapter sets forth our theme of integrating clinical science and clinical practice. We discuss the philosophical and practical or applied aspects of clinical psychology and place clinical psychology in perspective relative to the historical, social, gender, cultural, and scientific environments in which it was created and in which it and we, as clinical psychologists, exist.

Our model is based on clinical psychology as a general treatment model, with the clinical psychologist serving as a primary care practitioner: the “psychological family doctor.” This chapter also delineates the direction and plan for the book.

Learning Objectives

At the end of this chapter, the reader should be able to:

• List five historical markers in the conceptualization and treatment of clinical phenomena.
• Identify three scientific eras that have influenced the development of clinical psychology.
• Describe the contemporary organizational environment of the field of clinical psychology.
• Explain the concept of the clinical psychologist as a primary care practitioner.
• List at least 10 learning objectives for reading the chapters ahead.

Mary, a doctoral-level psychologist, was at a party where the hostess introduced her to someone by saying, “This is Mary. She’s a psychologist.” The
other person smiled and said, “Whoops. I better be careful what I say so you won’t be analyzing me.” Mary’s response was that she was not a clinical psychologist, but an experimental psychologist working on aspects of language acquisition in chimpanzees.

It is of more than passing interest to know that many people who hear the word psychologist assume that the person so identified is a clinical psychologist. Many people use variations of the term psychology to denote motivation (“I am really psyched for that date”), readiness (“I am psyched for that exam”), intimidation (“I really psyched him out”), or a person who appears to be out of touch with reality or with societal norms (“That guy is really psycho”). The range of psychology applications and practice is discussed in Chapter 2. In this introductory chapter, we discuss the history and development of clinical psychology as a practice, a science, and a treatment; and we place clinical psychology in perspective relative to the historical, social, gender, cultural, and scientific environments from which it emerged.

Writing a text such as this one takes a great deal of thought and discussion among the authors. We have had to decide what to include, what to exclude, and how to present the material in as scientific, readable, and useful way as possible. We have, between us, over a century of experience, first as students and then as university faculty members and practitioners. We are aware of the challenges in developing a text. Will it hold your interest? Will it allow your instructor to elaborate on the ideas we present? Will it provide the requisite information? The latter two points are in fact relatively easy to fulfill. To keep you interested is a much harder job. For this reason, we have decided to talk to you directly and to think of you as one of our students.

The clinical psychologist, in the simplest definition, works in a clinical setting, with clinical populations, and uses clinical interventions. But what does that mean? Clinics are usually for people needing treatment of one sort or another. A look at a hospital directory might list the hours of operation for the spine clinic, the asthma clinic, the well-baby clinic, or the mood clinic. That is where you would expect to find clinical psychologists. Although this has been true for much of the existence of clinical psychology, the appellation of clinical has now been affixed to other terms such as clinical health psychology, clinical child psychology, or clinical neuropsychology.

The notion that people have emotional problems is not new. That some people act unacceptably within their social or family group and are thought to be deviant from their fellows is, instead, an ancient belief. Rather than dazzling (or amazing) you with the historical or prehistorical experience of psychology, we have decided to make it easy.

We are going to take you for a ride on an incredible magic carpet. Not only can it fly though the air, it allows you to board without going through a metal detector. Second, it can travel through time so that we can view many experiences, circumstances, and situations. Third, it renders us invisible so that we can observe others and not be seen. Fourth, it is soundproof so that we can discuss what we are seeing without being heard. Fifth, if, for any reason, our trip is interrupted, you can climb aboard again and take up where you left off. Sixth, this magic carpet has a universal translator that allows us to listen in to what is going on in front of us. Finally, it will safely return us to our starting
point. Please note that no snacks will be served on this flight so before embarking, collect your favorite snacks to take along.

A Flying Carpet Tour of Clinical Psychology

If you are safely aboard, our first stop is prehistory. We can feel the heat. We are on a plain in Africa. A formerly social and well-adjusted member of the tribe has been howling at the moon, attacking other members of the tribe, and having uncontrolled seizures or other acts against the best interest of the tribe, clan, or group. He has been caught and subdued by other members of the tribe and has been rendered unconscious by being forced to drink a potion the tribal healer has concocted from herbs and flowers. The healer is about to perform a surgical procedure still used today, called trephining. She is using sharpened flints to bore a hole in the person’s skull to release the demons and spirits that have been trapped there. Releasing the demons should relieve the patient of their “possession.”

Although we might expect the patient to die from what we see as a barbaric operation, skulls dating back thousands of years have been found with holes drilled in the skull, and the regrowth of bone indicates that the person survived. Scientists think that the holes were drilled to release demons that inhabited the individual causing aberrant behavior. In other cases, the clan healer might simply offer potions made from roots, barks, or leaves of plants as prescriptions for various disorders. Some combinations of drugs calmed the angry patient, and others likely energized the inactive individual. What we now call “folk” remedies were the earliest attempts at dealing with the broad range of illnesses, including those that we now label as psychological disorders. If we listen carefully, we might hear the healer give the man’s wife a bag of herbs and leaves, and instruct her to brew a tea with them when the man awakens from his surgery.

If you will hold on tight, we are going to move on to ancient Greece. Before we fly into the office of a healer, there are some things that you need to know. The Greeks posited that there were four basic elements; fire, water, earth, and air. As all persons were constructed of these elements, their balance within the body was of major importance. Each element would correspond with a particular characteristic that would create a humor within the body: fire = blood humor; earth = black bile humor; water = yellow bile humor, and air = phlegm humor. Fire, of course, was hot. Water was wet. Earth was dry, and air was cold. The particular humoral mix could be seen in the person’s personality and behavioral style. These ideas seem quaint to us today, but we still refer back to them. An angry person is said to be “hot-blooded” or to have a “fiery temper.” The old term for depression, melancholy, stems from the terms melan (black, as in melanin) and choli (bile, as in colon). Melan + Coli = melancholy. We may describe someone as phlegmatic, meaning “subdued.”

In the quarters of the ancient Greek healer, we have an opportunity to watch a treatment. The healer is assessing the patient’s humoral mix and will then prescribe a treatment. The patient reports that he is often angry, and the
anger involves him in physical fights with family, friends, and even strangers. The healer is recommending bloodletting as the treatment of choice to lower the force of the blood humor that is obviously creating the problem. The patient lies on a couch and the healer cuts into the patient’s arm and blood flows copiously into a bowl held by the healer’s assistant. When the healer has seen enough blood flow, she will stanch the bleeding with folded linen and pressure. The patient will then rest. Other treatments might include enemas to relieve the excess of black bile, forced purging or the use of emetics for yellow bile, or compression of the chest for too much air.

If you found that scene a bit unpleasant, be forewarned that the next stop may be even more visceral. We are now in medieval France. We are flying over a walled town, and in the middle of the town square workers are preparing for an execution. They are piling branches and wood around a stone column. Set high in the column is an iron ring. We are all thinking the same thing. They are planning on burning someone to death. There, off to the right we can see a woman being dragged toward the post. We can hear the charges against her being read.

Fortunately our carpet allows us to understand medieval French. The prisoner was found guilty of practicing the black arts, witchcraft. The court, a church court it seems, has sentenced her and two other women to be burned as witches. Her hands are tied to the iron ring and her feet secured. She is gagged so she cannot say anything or cast a spell. A torch is lit. I think it is time for us to leave this place.

In the Middle Ages, the church developed as an arbiter of both what is normal and what is abnormal, and then offered “cures” for the abnormal behavior. These cures ranged from prayer and meditation to exorcism and execution. The inquisition brought with it the beating, flogging, burning, hanging, and drowning of those suspected of trafficking in the black arts. Interestingly, those black arts included healing and midwifery. If a town was unfortunate enough to have a disease manifestation such as the plague, it was considered the work of witches. Only a concerted search for the witches and their immediate eradication could cleanse and heal the community.

Our next stop is going to be the seventeenth-century town of Salem, Massachusetts. We think that you know what we will find. We are in a courtroom. As you can see, everyone is dressed just like the Pilgrims in the pictures of the first Thanksgiving. This, however, is no celebration. A woman is dragged into the courtroom and brought before the two judges. The charges against her involve witchcraft. The accusers are three teenage girls who report having seen the woman muttering “spells” and having a conversation with her cat. Some of the woman’s neighbors testify that they, too, saw her “acting strangely,” though other townspeople testify that she is a harmless person who caused no problems for anyone.

At that moment, we see something incredible. The teenage accusers fall to the floor of the courtroom and seem to be having spasms and convulsions. They point to the woman as they are doing it. Amazingly, the girls’ behavior is entered as “evidence” against the woman and she is pronounced a witch and sentenced to burn. We would later learn of the death of several women based on the report of these teenage girls. Interestingly, when it was decided to stop using the girls’ behavior as evidence, the girls’ spasms ceased.
Our next stop on this magic carpet is outside Paris on a sunny Sunday afternoon. The year is about 1785. It is before the French Revolution, and the wealthy and elite of Paris are obvious. We can see carriages arriving, and well-dressed men and women are emerging from the carriages. It seems that their destination is a mental hospital called Salpetrière. The visitors do not seem intent on seeing a relative who might be residing in this particular hospital, but rather they are strolling along and viewing the inmates as if visiting a zoo. We can see some inmates posed in postures that they seem to hold for exceedingly long periods. Other inmates are playing with pieces of wood. A woman is cradling a rag as if it were a baby. The onlookers delicately cover their noses with perfumed handkerchiefs to block the odor coming from feces-encrusted inmates, rotting food, and inadequate hygiene facilities. Servants are setting a picnic lunch for some of the sightseers . . . far away from the hospital building.

A quick trip over the English Channel takes us to an English hospital for lunatics: St. Mary Bethlehem, also known as the Bethlem Royal Hospital. Coming from within the walls of this building we hear the rumble of human voices. Some are shouting, some are crying, and some are making noises that we cannot interpret. When we hear the cacophony, we think that this place sounds as if it is out of control. It seems to exist without any sense of order. There is confusion and uproar everywhere. It is, in fact, pure bedlam—a contraction of the hospital’s name still used to denote what we are witnessing. Bedlam is the uncontrolled and confusing events and actions we see in the midst of crises. We see visitors touring the hospital who, like their Parisian counterparts, are laughing and mocking the residents. Some are even carrying long poles to prod the patients and make them angry within their cages so that they will react with outrage and produce a better “show.” The guardians of these patients do nothing to protect their charges.

We fly back to eighteenth-century Paris and stop at the salon of a physician, Dr. Franz Anton Mesmer. He was born in 1734 and died in 1815. He was credited by some as having accidentally discovered the idea of group therapy. Mesmer argued that health or illness was a result of the harmony or discord between the bodily fluids and the planets (e.g., “lunacy” was a result of the gravitational pull of the moon). He later redefined his theory and suggested that harmony or discord within the individual was a result of some distortion of the internal magnetic fields.

Let’s observe Mesmer at work. Several patients are sitting around an oak tub, and the “magnetic fluid” is sending magnetic forces through iron bars that patients are holding as extensions from the tub. Mesmer is walking around and speaking soothingly and quietly to the patients. He lays his hands on them and evaluates the balance of their magnetic fluid. Some of the patients in his treatments appear to faint or swoon and others seem to sit transfixed during their treatment. We would later learn that in the spirit of the time, scientific support was deemed to be the mark of any treatment. After an investigation by the Paris Academy of Sciences, Mesmer’s model of treatment was found to be without merit and the academy would not support it. Although Mesmer later died in obscurity, his name lingers far beyond his treatment to describe someone who is mesmerized as being fixed on an object or in a trancelike state.
We now fly ahead to Vienna in the early twentieth century, where a young neurologist has been building quite a reputation for himself. Dr. Sigmund Freud, frustrated at not getting the faculty appointment that he so badly wanted in the Department of Neurology at the University of Vienna, is about to give a lecture. He has abandoned his academic quest and has started a practice to treat patients who have what he calls “nervous disorders.” Freud has not yet come to the podium and we can hear comments and discussion by members of the audience. “I’m aghast at some of the things that I heard about him,” commented a lawyer. “Well, he writes rather nicely, but some of his statements are a bit, how shall I say this? Over the edge,” responded an accountant sitting nearby. A businessman commented, “His work is unsavory, at the least.” A fourth commented, “Well, he is one of us, so we should listen respectfully.”

Freud comes to the stage and is introduced as the speaker of the evening. The president of the Vienna lodge of B’nai B’rith, a group of Jewish professionals, presents Freud and his topic: The Interpretation of Dreams. We can only wonder what Freud has done or said to make it so difficult for him to get a hearing on this subject from his medical colleagues. He has sought to go to the people for this presentation. The group listens to his presentation, but by the shakes of their heads, and the shared smiles, they are finding his presentation of dreams as the “royal road to the unconscious” a bit much.

Let’s get back on our carpet and take a quick trip forward. World War I has broken out, and we are in an army recruitment center in 1917. Recruits are being given a test to determine their abilities and aptitude. The results of the tests will help in placing the soldiers where the military can gain the greatest value from their contributions. Two officers are discussing the testing program. “Darn shame this test. What they need to do is fight. Just courage and a gun is what they need. They’ll do what we tell them to do just like before, and heaven help them that doesn’t do what we tell them.” The second officer responds that he had experiences in Cuba some 20 years earlier with soldiers who appeared to understand instructions, but were later killed. “We need to build a core of competent, intelligent soldiers and more intelligent officers. Maybe this way of selecting them will make a difference.”

The second officer does not know how prophetic he is. Binet’s work will be the basis for the Army Alpha and the Army Beta tests in years to come. The Army Alpha and Beta tests were standardized measures for screening large numbers of people to optimize recruit placement. These tests identified aptitudes and skills to determine which positions in the military would be suitable for an able recruit. Each test served the same purpose, but the Beta test could be administered to individuals who did not speak English as a primary language. The fact that all individuals could be examined with these assessments became significant not only for military recruiting purposes at the time but also for clinical applications after the war.

Hold on. We leave again and head for England. It is 1938 and we are observing an old man speaking into an early wire recording machine. He speaks slowly and deliberately because of the prosthesis in his mouth. His speech is somewhat muffled but we can make out his English. It is Sigmund Freud speaking of his career:
I started my professional activities as a neurologist trying to bring relief to my neurotic patients. Under the influence of an older friend [Josef Breuer] and by my own efforts I discovered some important new facts about the unconscious, insight, the role of instinctual urges, and so on. Using these new findings, I developed a new science, psychoanalysis, a branch of psychology as a new method for the treatment of the neurosis. I had to pay heavily for this bit of good luck. People did not believe in my facts and thought my theories unsavory. In the end I succeeded in acquiring pupils and bringing up an international psychoanalytic association. But the struggle is not yet over.

He stops for a moment and then says, “Sigmund Freud.” We know that he died of cancer the following year. It must make us thoughtful that by his own words, Freud saw psychoanalysis as part of what we would call clinical psychology.

Next we travel to the United States. It is 1944, and we are looking in on a military strategy meeting at the Pentagon in Washington, DC. The Army is pondering what to do about World War II soldiers suffering from combat fatigue. (In World War I, it was called shellshock.) “We need to be able to do something with these boys,” declares a colonel. Wearing the insignia of the medical corps, he argues for more psychiatrists for both field hospital work and behind the lines. The brigadier general asserts, “If they are doctors, we need them to be cutting and patching these kids up to save their lives. I am less worried about their mental health if they have shrapnel in their gut.” A major tentatively raises his hand. “What about the possibility of using psychologists to deal with the psychological problems? They are not physicians but they have studied about helping people with psychological problems.” “Where would we find them?” asked the colonel. “I can contact several universities and see who might be available,” replied the major. “Do it,” commands the general.

Our next stop is at a coffeehouse in Witwatersrand, South Africa. It is the early 1950s. A young psychiatrist is discussing an idea with another colleague. “It seems obvious. If patients are anxious, they have great difficulty being relaxed. If they are relaxed it is hard to be anxious. What if we can teach anxious patients to relax? Wouldn’t that ease their problem?” His colleague shook his head. “Dr. Wolpe, don’t be foolish! You are a trained psychoanalyst. You know that the anxiety is a symptom of the underlying conflicts. Sure, we can remove the anxiety for a moment or two, but it will return. Even if we help to remove the anxiety about one situation, it will only return in another symptom. Besides, the complexity of the anxiety disorders cannot be explained in so simple a paradigm.” We can only smile knowing the enormous impact that Joseph Wolpe had on his generations of students and thereby on millions of anxious patients.

Back to the Future

At this point, we come back and land our magic carpet. The rest of the history of clinical psychology belongs in today’s world. The associations, organizations, divisions, meetings, certifying bodies, and philosophies of practice are contemporary.
Yet in the practices, publications, and missions of these institutions, we see the historical influence of the people, events, and scientific eras that have shaped the field of clinical psychology.

Major Organizations Concerned with Scientific Practice

Major organizational bodies relevant to the professional culture of clinical psychology include the American Board of Professional Psychology (ABPP), the American Psychological Association (APA), and the Association for Behavioral and Cognitive Therapies (ABCT). Each of these organizations has specialty subdivisions that reflect the growing complexity of clinical psychology. Established in 1948, the American Board of Examiners in Professional Psychology (now shortened to American Board of Professional Psychology), offers advanced certification of competency in a subspecialty of clinical psychology. These specialties include clinical psychology, clinical child and adolescent psychology, and clinical neuropsychology.

Founded in 1892, the American Psychological Association (APA) is the largest worldwide association of psychologists. With approximately 150,000 members, the APA offers a vast number of programs and initiatives, including 56 numbered divisions or special interest groups that focus on particular topics. Clinical psychologists are often affiliated with the following APA divisions: Clinical Psychology (12), Psychotherapy (29), Psychoanalysis (39), Psychologists in Independent Practice (42), and Society of Clinical Child and Adolescent Psychology (53). There are many other divisions that the clinical psychologist might be interested in joining. For additional information, see www.apa.org.

APA Division 12—Clinical Psychology

APA members who belong to this division are active in practice, research, teaching, administration, and study in the field of clinical psychology. Graduate students in APA approved or regionally accredited doctoral programs may become student affiliates. Members and student affiliates may also join one or more sections of the division: Section II: Clinical Geropsychology; Section III: The Society for a Science of Clinical Psychology; Section IV: Clinical Psychology of Women; Section VI: Clinical Psychology of Ethnic Minorities; Section VII: Emergencies and Crises; Section VIII: Association of Psychologists in Academic Health Centers (APAHC); Section IX: Assessment; and Section X: Graduate Students and Early Career Psychologists.

APA Division 29—Psychotherapy

APA members who also belong to this division share in fostering collegial relations among APA members who are interested in psychotherapy. This division stimulates the exchange of information about psychotherapy, encourages the evaluation and development of the practice of psychotherapy, educates the public about the service of psychotherapists, and promotes the general objectives of the APA.
APA Division 39—Psychoanalysis

This division encompasses the diversity and richness of psychoanalytic theory, research, and clinical practice. The nine sections within Division 39 represent members’ broad interests: (I) Psychologists-Psychoanalyst Practitioners; (II) Childhood and Adolescence; (III) Women, Gender, and Psychoanalysis; (IV) Local Chapters; (V) Psychologist-Psychoanalysts’ Clinicians; (VI) Psychoanalytic Research Society; (VII) Psychoanalysis and Groups; (VIII) Section on Family Therapy; and (IX) Psychoanalysis of Social Responsibility.

APA Division 42—Psychologists in Independent Practice

This APA membership division deals with psychological services in all independent practice settings and advocates on behalf of consumers of these services. Through its committees and task forces, it promotes quality and accessibility. The division also provides a forum for issues affecting independent practice at the APA convention and at the annual Practice Development Conference.

APA Division 53—Society of Clinical Child and Adolescent Psychology

This group of APA represents psychologists who are active in teaching, research, clinical services, administration, and advocacy in clinical child psychology. The division has established research and professional service awards, including an annual student research award and also sponsors publications describing graduate programs and clinical internships that provide specialized training in clinical child psychology. The division also supports task forces on the development and evaluation of evidence-based treatments for childhood disorders and coordinates efforts for dissemination of information about evidence-based services.

Association for Behavioral and Cognitive Therapies

The Association for Behavioral and Cognitive Therapies (ABCT; formerly the Association for Advancement of Behavior Therapy) was founded in 1966. The founders were among the elite of behavior therapy, but many mainstream psychologists considered the ABCT to be a radical splinter group.

Although ABCT draws members from various mental health disciplines (psychiatry, social work, psychiatric nursing, counseling), the bulk of the approximately 5,000 member organization comprises clinical psychologists who share a fundamental interest in integrating science and practice. Their mission is to relieve human suffering by designing, testing, developing, and disseminating culturally sensitive methods that work, based on the latest scientific advancements (www.abct.org). Advancement of empirically based practice was the original momentum for the founding of this organization. Over time, scientific developments have led this group toward focusing on cognitive innovations and discoveries, and the name of the organization was officially changed in 2004. Because cognitive-behavior therapy is based on broad principles of human learning and adaptation, it can accomplish a wide variety of goals. The
therapy has been applied to issues ranging from depression and anxiety to the improvement of parenting, relationships, and personal effectiveness.

**Training Philosophy in Clinical Psychology**

In 1949, at the request of the newly formed Committee on Accreditation of APA, the National Institute of Mental Health (NIMH) sponsored a conference in Boulder, Colorado, to discuss the development of standards for training in clinical psychology. This conference was, in effect, a step in the government’s initiative to tap the resources of psychology for the WWII effort, circa 1944 Washington, DC. Although some clinical psychology training programs were in existence at the time, the content, length, format, requirements, and missions varied. All the programs were housed in university departments, but some were in graduate schools of arts and science and others were in schools of education.

The government connection was a boon to the development of clinical psychology. The Veterans Administration (VA) and the NIMH offered training funds for internship sites. The ideas and protocols developed at the Boulder conference became known as the “Boulder Model” for clinical training. The participants at the conference agreed that the minimal training must include a PhD, thereby placing psychologists squarely in the midst of their academic colleagues in other disciplines. Psychologists were to be scientists and therefore would be trained to be competent in research as well as the development of clinical skills and competencies. This dual emphasis resulted in the notion of the clinical psychologist being educated and trained as a scientist-practitioner.

The Boulder conference established the following parameters for doctoral training in clinical psychology:

- Boulder-model programs in clinical psychology award the PhD degree.
- The appropriate location for clinical psychology training is a university department, usually in a faculty of arts and science, not in a separate school that is part of a university (e.g., law, medicine, dentistry) or in a free-standing school (e.g., many schools of medicine).
- The program can be one of several programs within an academic department.
- Clinical psychologists are to be prepared for work in both the academic world and the practice world.
- The APA Committee on Accreditation provides an approval and accreditation for training programs in clinical psychology. The accreditation process, though meticulous and sometimes arduous to complete, has made the designation “APA accredited” the gold standard for clinical psychology programs.
- The PhD programs require a research-based dissertation as a requirement for the completion of the degree.
To provide maximum funding through grants, fellowships, and scholarships, small numbers of carefully selected students are admitted.

Limiting the number of students facilitates maximum mentorship of students, as the goal is successful training of every student accepted for admission.

The scientist-practitioner model was questioned by many practicing clinicians. As early as the 1960s, the scientist-practitioner emphasis was under scrutiny. As an alternative approach to training, the California School of Professional Psychology was founded by Dr. Nicholas Cummings in 1969. Cummings, a former president of APA and a behavioral science entrepreneur, worked with the California State Psychological Association to develop a PhD program that more strongly emphasized the applied clinical aspect of clinical psychology. Cummings, who is president of the Foundation for Behavioral Health and Chairman of the Nicholas & Dorothy Cummings Foundation, Inc., was the founding CEO of American Biodyne (MedCo/Merck, then Merit, now Magellan Behavioral Care), the first U.S. behavioral managed care company. Dr. Cummings has also founded four campuses of the California School of Professional Psychology, the National Academies of Practice, the American Managed Behavioral Healthcare Association, and the National Council of Professional Schools of Psychology. Cummings has advanced the view that clinical psychologists should be trained to be knowledgeable consumers and contributors to research, but that this is secondary to skill development for clinical interventions.

The issues raised by Cummings and others led to a second major conference on training philosophy held in 1973 in Vail, Colorado, and the proceedings of this conference became known as the “Vail Model.” The Vail conferees endorsed different principles from those endorsed by the conferees at the earlier Boulder conference, leading to an alternative training model (D. R. Peterson, 1976, 1982). Psychological knowledge, it was argued, had matured enough to warrant creation of explicitly professional programs along the lines of professional programs in medicine, dentistry, and law. These professional programs were to be added to, not replace, Boulder-model doctoral programs. Further, it was proposed that different degrees should designate the scientist-practitioner role (PhD; emphasis on the term scientist) from the practitioner-scholar role (PsyD—Doctor of Psychology; with emphasis on the term practitioner).

The Vail conference asserted the following parameters for doctoral training in clinical psychology:

- Vail-model programs in clinical psychology award a Doctorate of Psychology degree, referred to as a PsyD.
- Vail-model programs can be housed in three types of organizational settings. They are found in a psychology department that is part of a university setting. They are also found in a university-affiliated professional or psychology school that may be part of a university. Or, they exist as independent, freestanding schools of professional psychology. The latter programs are not affiliated with universities; but rather are independently developed and staffed.
• These professional training programs focus primarily on clinical practice and less on research, but graduates should know how to do research and how to appropriately access and use research to inform their clinical practice.

• Professional schools can be not-for-profit or for-profit institutions and several schools of professional psychology are affiliated in a network of freestanding professional schools. These schools offer doctoral programs in clinical psychology, and graduate work in counseling and master’s level programs.

• PsyD programs are responsive to the market demands for clinical services in their enrollment policies and procedures. Compared with PhD programs, they will enroll as many as three times the number of incoming doctoral candidates per school (Mayne, Norcross, & Sayette, 1994). Over time, this will create greater numerical parity in psychologist graduates from scientist-practitioner programs.

The differences between clinical PhD and clinical PsyD programs are quantitative, not qualitative. The primary disparity is in the relative emphasis on research. Boulder programs aspire to train producers of research who will work within academic settings and agencies. Vail programs train consumers of research and individuals who will be the therapists and supervisors of therapists in community agencies. The clinical opportunities for licensure and practice are similar for students in both programs.

Several studies demonstrated that initial worries about stigmatization, employment difficulties, and licensure uncertainty for PsyDs have never materialized (Hershey, Kopplin, & Cornell, 1991; D. R. Peterson, Eaton, Levine, & Snepp, 1982). Nor are there discernible differences of late in employment except that the research-oriented, PhD graduates are far more likely to be employed in academic positions and medical schools (Gaddy, Charlot-Swilley, Nelson, & Reich, 1995).

In terms of application and acceptance rates, PsyD programs average 141 applications and 53 acceptances, but there are significant differences as a result of institutional location (Norcross, Sayette, & Mayne, 2002). Freestanding programs, on average, receive twice the number of applications as university department programs (with university professional schools in between). Similarly, the freestanding programs accept significantly more of the applicants than both types of university-based programs. The average acceptance rate for PsyD programs is 40% to 41% (i.e., 4 out of 10 applicants to a PsyD program are accepted). By contrast, the average acceptance rate for clinical PhD programs is 11% to 15% (i.e., 1 or 1.5 out of 10 are accepted).

Student Characteristics

The educational and demographic characteristics of PsyD and PhD students are similar, but there is an interesting trend across the field. Seventy percent of all clinical psychology doctoral students are now women, and about 20% are members of ethnic or racial minorities. The one difference between programs is that
students in PsyD programs are far more likely to have master’s degrees already (and tend to be older) than PhD students who typically come right from undergraduate programs. About 35% of incoming PsyD students possess a master’s degree, compared with about 20% in PhD programs (Norcross et al., 2002).

**Licensure in Clinical Psychology**

It has been said that when psychologists are under attack we circle the wagons and shoot at each other. To some, this might seem to be the state of affairs in obtaining the privilege to practice psychology through state licensure. Each state board of professional psychology maintains its own requirements. Some use the title “Clinical Psychologist” (e.g., Illinois, which has the designation of licensed clinical psychologist). Indiana uses the term “Health Service Provider in Psychology” as the designation for independent practice, and Pennsylvania has a generic psychology license. The state boards also set minimum requirements (e.g., graduation from an APA accredited program). Some states require a test on ethics, others an essay examination in research, and others an oral examination before a committee of the board. Some states accept ABPP diploma status as a credential, whereas others ask that membership in the National Register be a credential for admission to the board process.

However, the good news is that there is a definite trend toward establishing more consistency and continuity in professional credentialing standards across states. It only makes sense that professional mobility serves the best interests of the public. With appropriate checks and balances to address the times when such mobility might be a risk to the public (e.g., an unscrupulous practitioner is running away from his or her latest mistakes and seeking a new venue for exploitive or unprofessional practices), qualified providers will be able to practice in different locations as their lives and interests may take them to new places. To learn more about licensure and credentialing matters, including the option to “bank” one’s credentials for mobility across states and future needs, consult the Association of State and Provincial Psychology Boards (www.asppb.org).

**The Practicing Role of a Clinical Psychologist**

What is most important for you, our students, is that clinical psychology is constantly changing. By the time you have completed your graduate work (either PhD or PsyD), the field will have evolved beyond what we describe in this text. Areas such as clinical health psychology, almost unknown a decade ago, have become a major emphasis for clinicians. We work with physicians in health care settings; lawyers in forensic settings; aerospace specialists, who look at behavior in space; and the military, who want to ameliorate the consequences of training, battle, and homecoming from war.

Today’s practicing clinical psychologist is a primary care provider and can be likened to a family doctor who treats a variety of problems. Ideally, there is
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no stigma to consulting a clinical psychologist. The clinician offers help with many challenges in living such as child-rearing issues, school-related problems, interactions with medical services (pain management, medication compliance), substance abuse problems, issues in dealing with aging parents, and the full range of emotional and behavioral disorders. This primary care function does not mean that every individual enters therapy. Instead, the psychologist may provide brief consultations (1 to 3 meetings), short-term treatments (3 to 20 visits), or extended intervention as appropriate. A professional relationship with the psychologist may extend over many years and include multiple family members. The clinician is a continuing psychological resource, to be consulted on an “as needed” basis.

Preview of the Text

The following chapters in Part I detail the foundation of clinical psychology. In Chapter 2, the activities of a clinical psychologist are described in greater detail. Rather than focusing on a single area, we describe the overall professional culture and its subspecialties. We detail the similarities and differences between clinical psychology subspecialties such as community psychology, health psychology and behavioral medicine, neuropsychology, forensic psychology, pediatric and child clinical psychology. The emphasis is on the common elements and relationships of clinical psychologies. In addition, we offer a glimpse into the lives of contemporary colleagues to provide perspective on living and working as a clinical psychologist.

Chapter 3 emphasizes the importance of understanding cultural differences and similarities when working with diversity. We first define cultural diversity and describe how it can impact—both positively and negatively—our clinical formulations and interventions. Becoming a sensitive and aware clinician is essential. We explore many psychological processes that influence our perceptions of culture and diversity, and we offer practical suggestions for integrating what we know about cultural variables into the context of what we do in clinical settings.

In Chapter 4, we discuss clinical research and outcome assessment in a highly understandable format. The importance of empirical support for clinical psychology is discussed. We describe and discuss various research models including experimental, quasi-experimental, observational, and case study designs. The question of how we know which treatments are effective is explored as we describe an outcome assessment framework for clinical practice.

Chapter 5 explores why (or how) people become patients. What brings them in? What are they looking for? How has their life circumstance evolved into one that now is maladaptive at its best and pathological at its most severe? There are at least 12 common “d” words that describe why people seek therapy. The individual, family, or couple may be: discomforted, discontented, distressed, disabled, dysfunctional, disconnected, dispirited, disgusted, distraught, dissatisfied, dyscontrolled, and disorganized. This first clinical chapter will discuss the broad
issues of psychopathology and adaptation that affect the client’s general functioning and quality of life, health, and well-being.

To best understand psychopathology, we use the multiaxial diagnostic systems of *DSM-IV-TR* (American Psychiatric Association, 2000) and of *ICD-10*. An individual is rarely totally pathological or incapacitated. To clarify this issue, we discuss the interaction of function and psychopathology and how we determine the point at which “normal” behavior becomes pathological. Finally, we discuss the specific treatment goals of therapy. Are we working to help the client “feel better,” or is our goal to help the client to “get better?”

In Part II, “Basic Techniques for Clinicians,” we begin our discussion of clinical issues. (This is really what you came for, isn’t it?) Basic techniques are considered in two main subsections covering assessment and intervention.

The next three chapters cover the foundation of clinical intervention—the clinical assessment. The reader becomes firmly grounded in the scientific approach to clinical practice, where the forming of hypotheses and the collection of data are essential for everything we do. In Chapter 6, we introduce the purpose and goals of clinical assessment, the types of assessments, and the biopsychosocial model for understanding human behavior. This model directs us to look at the biological/physiological/neurological correlates of behavior as well as the psychological and social/environmental elements.

In Chapter 7, we continue the scientific approach to assessment, starting with an explanation of a data-oriented model. Our discussion focuses on structuring the assessor’s critical thinking to be the best consumer of available information, including scientific information on different assessment devices. Using the scientific method to approach assessment gears the clinician toward hypothesis testing, taking an operational approach to targeted domains, and using a multimodal, multimethod, time-series assessment, as appropriate.

Chapter 8 continues the discussion of data collection strategies and tools, taking a closer look at how to build an assessment protocol, how to decide what needs to be assessed, and how to integrate clinical assessment into clinical practice. We discuss the use and integration of psychological assessment tools including clinical interviews, psychological testing, observation, report of significant others, report of other professionals, and self-report. A problem-solving approach to clinical decision making and assessment is emphasized to assist clinicians in the assessment and treatment process.

Part III addresses the “how to” of psychotherapy. The key issue to be mastered is that of case conceptualization (i.e., building models for understanding the client and developing appropriate interventions).

In Chapter 9, we focus on developing effective treatment conceptualizations. The highest order skill for the clinician is to develop a treatment model or conceptualization. We both define and describe the conceptualization process and describe how the treatment conceptualization informs the treatment plan throughout therapy.

Chapter 10 explains the next step in therapy, developing the treatment plan. We emphasize setting collaborative goals as well as developing and maintaining the therapeutic alliance or productive working relationship. Any relationship is filled with pitfalls and problems. The therapeutic relationship is no
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different. We identify the requirements of the therapeutic relationship, describe techniques for relationship building, and outline some benchmarks of a good working relationship.

It is hard to build a house without tools. It is equally difficult to build a therapy without specific methods or tools. In Chapter 11, we discuss specific methods or tools of intervention that you can add to your psychotherapy skills repertoire. These methods are grouped according to interpersonal or systems interventions, affective interventions, behavioral interventions, and cognitive interventions.

Chapter 12 involves understanding, facilitating, and evaluating change. We begin by exploring the basic principles of change and the concept of motivation to change. We then look at change in terms of dynamic stages, which helps us to better understand the many variations in how clients actually make progress toward their goals. Next, we return briefly to the topic of assessment as we discuss the measurement of change in therapy. Barriers to measuring change in applied clinical contexts are explained, along with ways to overcome these barriers. Finally, we illustrate the mechanism of communicating about change with clients, agencies, families, and cooperating professionals.

Next, we take a troubleshooting approach in our discussion of resistance and impediments to change in Chapter 13. There are several areas of impediment or resistance to change. These include how the patient can be a source of therapeutic impediment, how the therapist can be a source of therapeutic impediment, how the environment can be a source of therapeutic impediment, and how the psychological disorder can be a source of therapeutic impediment.

Therapy should not be viewed as a life sentence. In Chapter 14, an effective termination strategy is presented. We illustrate seven types of termination, on a spectrum from positive to unprofessional. We then explain the professional standards of care for competent termination. In addition, 10 applied skills for an effective termination are detailed.

In Part IV, Chapter 15, we discuss a frequently avoided but critically important topic. Few careers can be as taxing as clinical psychology. We are dealing with the feelings, actions, problems, traumas, and miseries of others. There is great weight in what we say and do because our actions have life-altering effects. In this chapter, which focuses on caring for yourself and your colleagues, we describe therapist burnout. As we consider ways to use positive psychology in our quest to thrive personally and professionally, we provide access to information on self-care ideas and resources that include the scientific knowledge generated in our own field.