CHAPTER TWO

Historical Overview of Clinical Psychology

FOCUS QUESTIONS

1. What theories have influenced the field of clinical psychology the most?
2. Why did personality assessment and diagnosis come back into favor?
3. How did clinical psychologists come to be so involved in the treatment of adult emotional problems?
4. How might clinical research inform clinical practice and clinical assessment?
5. What factors led to a "splitting" of the American Psychological Association membership?

CHAPTER OUTLINE

Reflection on the roots of clinical psychology can promote a better understanding of the field. This chapter provides a view of both the historical sweep of clinical psychology and some of the current issues that confront the field.

Historical Roots

Establishing a certain time period or designating a particular person as the beginning of clinical psychology can be arbitrary if not downright misleading. One can certainly go back to Greek philosophers such as Thales, Hippocrates, or Aristotle who, long before the birth of Christ, were speculating about human beings and the nature of thought, sensation, and pathology (Shaffer & Lazarus, 1952). Since these philosophers are cited as antecedents of nearly every profession, movement, or system of thought in Western society, their citation here does little, perhaps, except to affirm our honorable beginnings.

For the years prior to 1890, there is really very little in the history of clinical psychology to separate it from the history of abnormal psychology or, as Zilboorg and Henry (1941) termed it, "medical psychology." Reisman (1976) finds it more useful to search for the roots of modern clinical psychology in the reform movements of the 19th century, which ultimately resulted in improved care for the mentally ill. Such improvements, and the humanitarian impulses of those who encouraged them, fostered the faint beginnings of the mental health professions as we know them today (Hothersall, 1984). One of the major figures in this movement was Philippe Pinel, a French physician. Shocked by the senseless brutality that was the custom in 19th-century "mental hospitals," he managed to get himself appointed head of the asylum at Bicêtre and, later, Salpêtrière. Through kindness and humanity, he accomplished much in a very difficult field. Whether Pinel's accomplishments should be regarded as personal achievements or as logical developments growing out of the philosophy of Rousseau and the idealism of the French Revolution is unclear. In any event, his work was a milestone in the development of psychiatry, the mental health approach, and ultimately, of clinical psychology.

At about the same time, an Englishman, William Tuke, was devoting himself to the establishment of what might be called a model hospital for the humane treatment of the sick and troubled. In America, Eli Todd was laboring long and successfully to develop a retreat in Hartford for the mentally ill. Like his European counterparts, Todd emphasized the role of civilized care, respect, and morality. Through his efforts, it became less fashionable to regard mental patients as incurable. The search for psychological antecedents to mental illness and an emphasis on treatment had begun to replace the routine harshness of custody.

Another American who had a profound effect on the mental health movement was Dorothea Dix (Figure 2-1). She campaigned for better facilities for the mentally ill. With determination and single-mindedness, Dix pushed, prodded, and cajoled until government officials responded. Using the force of logic, facts, public sentiment, and good old-fashioned lobbying, she wrought her will. And in 1848, New Jersey responded by building a hospital for the "insane"—the first in a procession of more than 30 states to do so.

Out of the efforts of such people, the groundwork was laid for a field of clinical psychology. However, it would be a mistake to evaluate these contributions apart from the social forces and ideas of the time. In the 19th century, philosophers and writers were proclaiming the dignity and equality of all. Governments were beginning to respond. Even science, which was just coming into its own, contributed to the movement. An atmosphere of "knowledge through experimentation" began to prevail. A feeling that people can predict, understand, and perhaps even control the human condition began to replace older wisdom. This ferment in science, literature, politics, government, and reform combined to produce the first clear and unmistakable signs of new professions in what would come to be referred to as "mental health."

FIGURE 2-1 Dorothea Dix traveled from state to state for 40 years campaigning for more humane treatment and better facilities for the insane and the mentally retarded. During the Civil War, she was chief of hospital nurses for the Union forces.

These short sketches represent some of the roots of clinical psychology. In the following pages, we trace its development in the specific areas of diagnosis and assessment, intervention, research, and professional matters.

Diagnosis and Assessment

The Beginnings (1850–1899)

For many, the essence of clinical psychology has always been its emphasis on assessing differences among people. Much of that emphasis can be traced to Francis Galton, an Englishman. Galton devoted a great deal of effort to the application of quantitative methods to understanding differences among people. Pursuing his interests in sensory acuity, motor skills, and reaction time, he established an anthropometric laboratory in 1882.

This tradition was furthered by the work of James McKeen Cattell, an American. Despite the disapproval of Wilhelm Wundt, in whose laboratory he assisted, Cattell turned his attention to reaction time differences among people. He believed, as did Galton, that this was a way of approaching the study of intelligence. In fact, he coined the term *mental tests* to describe his measures (Thorndike, 1997). Through the use of a battery of 10 tests, Cattell hoped to discover the constancy of mental processes, even predicting that such tests could be used in the selection and training of people as well as in the detection of disease. In this early work, we can see the first halting steps of the testing movement.

A related trend of the same general period is illustrated by the diagnostic work of Emil Kraepelin in 1913. Few psychiatrists of the time could equal his professional stature. When Kraepelin divided mental illness into those types determined by exogenous factors (curable) and those caused by endogenous factors (incurable), he initiated a romance with classification schemes that persists even today. His descriptions and classifications of patients were heuristic and have served to stimulate an enormous amount of discussion about psychopathology.

The Advent of the Modern Era (1900–1919)

One of the major developments in this era was the rise of mental measurement or diagnostic psychological testing. The beginning may lie with Galton or Cattell, but the decisive impetus came from the work of Alfred Binet.

Binet was convinced that the key to the study of individual differences was the notion of norms and deviations from those norms. Following Binet's submission of a proposal to the minister of public instruction in Paris in 1904, a commission approached Binet and his collaborator Theodore Simon about developing a means of ensuring that children with cognitive limitations were properly educated (Thorndike, 1997). To distinguish

objectively among various degrees of limitations, the two men developed the 1908 Binet-Simon Scale. It is hard to overestimate the profound influence that this scale has exerted on the *measurement of intelligence*. Henry Goddard later introduced the Binet tests to America, and Lewis Terman produced an American revision in 1916.

Some progress was also being made in the area of *personality testing*. Carl Jung began using word-association methods around 1905 to attempt to uncover unconscious complexes. In 1910, the Kent-Rosanoff Free Association Test was published. Even though Galton had been experimenting with such techniques as early as 1879, these free-association tests marked a significant advance in diagnostic testing.

In 1904, Charles Spearman offered the concept of a general intelligence that he termed *g*. Edward Thorndike countered with a conceptualization that emphasized the importance of separate abilities. Whatever the truth, the great debate regarding the nature of intelligence was on—a debate that still rages today.

When the United States entered World War I in 1917, the need arose to screen and classify the hordes of military recruits being pressed into service. A committee of five members from the American Psychological Association (APA) was appointed by the Medical Department of the Army. Its chairman was Robert Yerkes. The committee was charged with the task of creating a system for classifying men according to their ability levels. It designed the Army Alpha test in 1917. This verbal scale was quickly followed by a nonverbal version, the Army Beta test. In a similar vein, Robert Woodworth developed his Psychoneurotic Inventory in 1917. This was perhaps the first questionnaire designed to assess abnormal behavior. With the advent of such rough screening instruments as Woodworth's Personal Data Sheet and the Army Alpha and Beta, the group testing movement was on its way.

Between the Wars (1920–1939)

Between the two world wars, there was substantial progress in diagnostic psychological testing. Pintner and Paterson introduced their nonverbal intelligence scale. In 1930, the Arthur Point Scale appeared, and in 1934, it was followed by the Cornell-Coxe test. In 1926, the Goodenough Draw-a-Man technique for measuring intelligence was published. The psychologist now had individual and group tests as well as verbal and nonverbal tests, and clinicians were using terms like "intelligence quotients."

Aptitude testing, epitomized by the Seashore tests of musical ability, was now in use. Interest tests had also made their appearance by this time. In 1927, the Strong Vocational Interest Blank came upon the scene, followed later by the Kuder Preference Record.

The continuing debate on theoretical issues in intelligence was further sparked in 1927 by Louis Thurstone's contribution based on factor analysis. Spearman, Thorndike, and Thurstone had all now entered the intelligence arena, and each made important contributions. In 1928, Gesell's developmental scales were published, and in 1936, Doll's Vineland Social Maturity Scale appeared. Doll's scale approached behavior not strictly in terms of intelligence but in terms of an individual's social maturity or competence.

A major development in the intelligence testing movement occurred in 1939, when David Wechsler published the Wechsler-Bellevue test. Until then, there had been no satisfactory individual measure of adult intelligence. Subsequent revisions of the Wechsler-Bellevue have served as the premier individual tests for adult intelligence.

Tests of intelligence, interests, and abilities were not the only testing developments in these years. The field of personality testing was also making great strides. Woodworth's Personal Data Sheet was followed in 1921 by the Pressey X-0 Test for emotions and in 1923 by the Downey Will-Temperament Test. The Allport-Vernon Study of Values came along in 1931.

However, the big news was projective testing. Although some beginning progress had already been made through the word-association research of Galton, Jung, and Kent and Rosanoff, the watershed event for projective testing occurred in 1921, when Hermann Rorschach, a

Swiss psychiatrist, published *Psychodiagnostik*. In this book, Rorschach described his use of inkblots to diagnose psychiatric patients. Rorschach's work suggested that when people respond to an ambiguous test stimulus, they will reveal something of their responses to real-life experiences.

It was not until 1937, when S. J. Beck and Bruno Klopfer published their separate manuals and scoring procedures, that the Rorschach method really caught on. Then, in 1939, L. K. Frank coined the term *projective techniques*. From that point on, a veritable flood of research publications, books, courses, and variations of projective techniques poured forth.

Another aspect of the projective movement is represented by the 1935 publication by Christiana Morgan and Henry Murray of the Thematic Apperception Test (TAT). This test requires the person to look at ambiguous pictures and then make up a story to describe the activities, thoughts, and feelings of the people in those pictures. The TAT remains a widely used projective device, probably second only to the Rorschach in popularity among projective tests. Then, in 1938, Lauretta Bender published her Bender-Gestalt test, which has also been used as a projective measure of personality.

World War II and Beyond (1940–Present)

Clinical psychology's success with intelligence tests was responsible for its subsequent movement into the area of personality assessment. As clinicians moved beyond the settings of the public schools and the institutions for those with cognitive limitations and into penal institutions, mental hospitals, and clinics, referring physicians and psychiatrists gradually began to ask more complex questions. Questions such as "What is this patient's ability level?" began to evolve into more complicated questions that dealt with differential diagnosis. For example, "Is this patient's level of functioning a product of constitutional intellectual limitations, or is a 'disease process' such as schizophrenia eroding intellectual performance?" Because answering such questions involved more than simply identifying an IQ level, new methods of examining the patient's performance on intelligence tests were developed. In many instances, the psychologist began to look at patterns of performance rather than just an overall score.

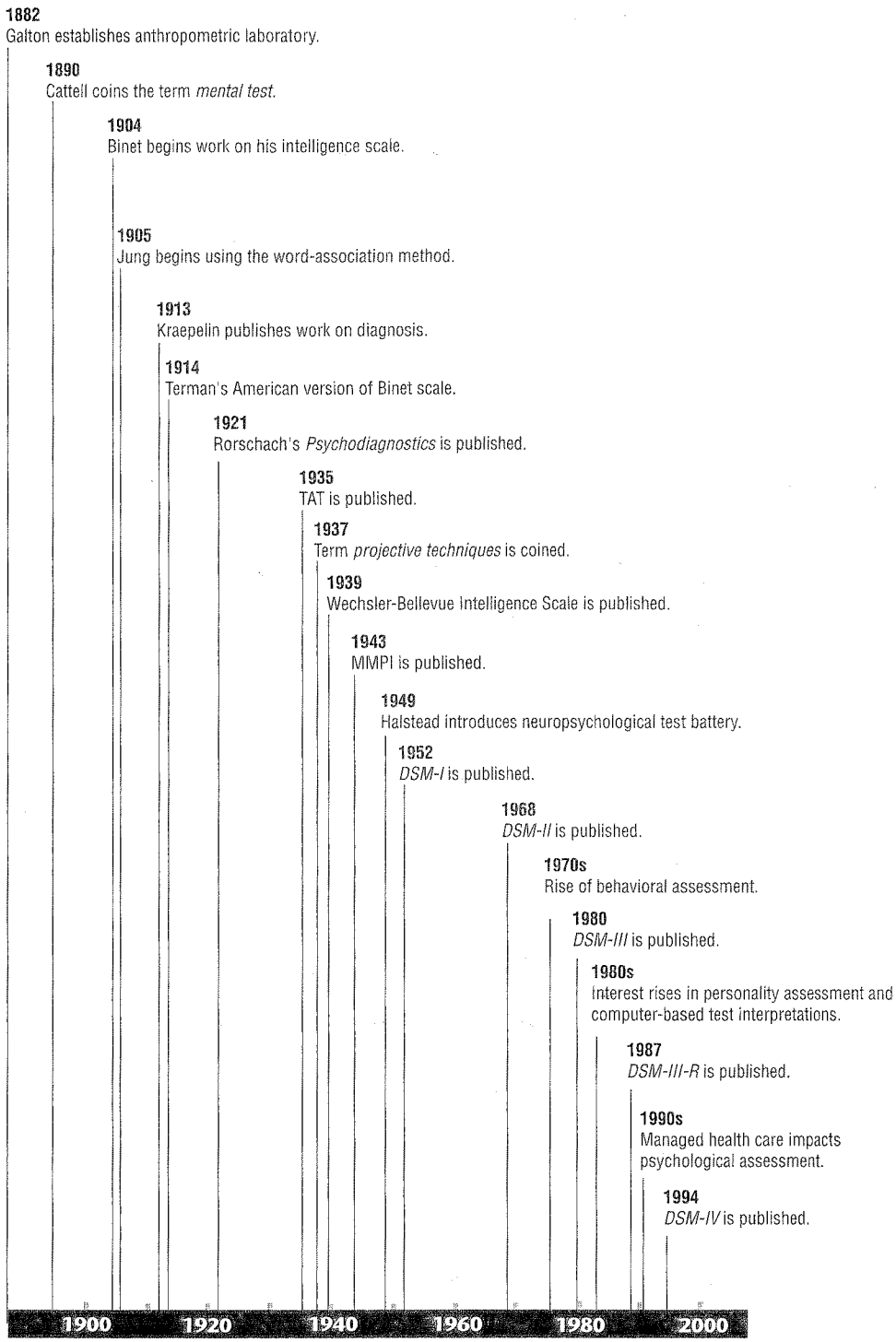
In 1943, the Minnesota Multiphasic Personality Inventory (MMPI) appeared (Hathaway, 1943). The MMPI was an objective self-report test whose major function, initially, seemed to be attaching psychiatric labels to patients. Although other tests such as the Rorschach were often put to similar uses, the MMPI was unique in that no theoretical interpretation of scores or responses was necessary.

The 1940s and 1950s witnessed a growing sophistication in testing technology. Triggered by the development of the MMPI, debates over the relative effectiveness of clinical and statistical prediction arose (Meehl, 1954; Sarbin, 1943). Which was superior—the clinician's subjective impressions or hard, objective approaches based on crisp data such as test scores that were readily quantifiable? There were also sophisticated discussions of methods of validating tests and guarding against misleading test-taking attitudes on the part of test respondents (Cronbach, 1946; Cronbach & Meehl, 1955). Assessment had come a long way since the crude instruments of the World War I era. Indeed, during this period, enough was known about constructing tests that APA could promulgate standards for their proper development (American Psychological Association, 1954).

In the aftermath of World War II, the importance of intelligence testing continued. In 1949, Wechsler published another individual test. This one, the Wechsler Intelligence Scale for Children, was to become a serious alternative to the Stanford-Binet. Later, in 1955, the Wechsler Adult Intelligence Scale (a revision of the Wechsler-Bellevue Scale) appeared. These tests marked the beginning of a whole series of subsequent revisions of children and adult forms of the Wechsler scales.

The 1940s and 1950s saw an explosive growth of personality tests, especially projective

TIMELINE: Significant Events in Assessment



tests. The Rorschach and the TAT continued in a preeminent position. Clinical psychologists were seen as experts in *psychodiagnosis*—the use and interpretation of psychological test scores as a basis for diagnostic formulation as well as treatment planning. However, a rift was growing within the profession as to whether objective or projective assessment measures were better suited to accurately describe personality and psychopathology. *Objective measures,* such as the MMPI and its revision, MMPI-2 (Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989), are based on a nomothetic approach to assessment in which test scores are interpreted using empirically based rules involving the contrast between an obtained score and the average score obtained from a large representative sample. Responses from projective measures, in contrast, are often interpreted using an idiographic approach. The focus may be more on the individual, and interpretations are often guided as much by psychodynamic theory as they are by empirically supported rules. This rift between those who favor either objective or projective techniques continues to this day.

Surprisingly, however, the major challenger to personality testing came from outside these ranks. Beginning in the late 1950s, a movement termed *radical behaviorism* began to assert its influence. Those who adhered to this orientation held that only overt behavior can be measured and that it is neither useful nor desirable to infer the level or existence of personality traits from psychological test results; personality traits, according to the radical behaviorists, cannot be measured directly. Personality assessment came under attack, and clinical psychology programs in the 1960s took on much more of a behavioral bent. In 1968, Walter Mischel made a strong case that traits exist more in the minds of observers than in the behavior of the observed. Situations, and not some nebulous set of traits, were said to be responsible for the ways we behave. In tune with this view, the 1970s would witness the rise of *behavioral assessment.* Behaviors were understood within the context of the stimuli or situations that either preceded or followed them.

Did this in turn mark the death of personality assessment? Actually, it did not. A resurgence of interest in the 1980s and 1990s can be attributed to the presentation and coverage of a variety of *personality disorders* in the American diagnostic system for mental disorders, the introduction of a number of more contemporary and psychometrically sound personality inventories (e.g., the Millon Clinical Multiaxial Inventory and the NEO-Personality Inventory), and several empirical demonstrations that personality traits do appear to be fairly stable across time and across situations (e.g., Costa & McCrae, 1988; Epstein & O'Brien, 1985).

As we mentioned, the official American diagnostic classification system has influenced the clinical assessment field. The first edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM-I)* appeared in 1952. Revisions of this manual have appeared periodically, the most recent one in 2000 *(DSM-IV-TR).* In addition to this diagnostic system's influence on the content of self-report inventories (new inventories were designed to measure the *DSM* mental disorders), it spurred the growth of another line of assessment tools—the *structured diagnostic interviews.* These interviews consist of a standard list of questions that are keyed to the diagnostic criteria for various disorders from the *DSM.* Clinicians (or researchers) who need to formulate a *DSM* diagnosis for a patient (or research participant) can use these interviews; it is no longer necessary to administer a psychological test and then infer a patient's diagnostic status from his or her test scores.

Interest in *neuropsychological assessment* has grown tremendously as well. Neuropsychological assessment is used to evaluate relative strengths and deficits of patients based on empirically established brain–behavior (test responses) relationships. Several devices were introduced to detect impaired brain functioning. In 1947, Halstead introduced an entire test battery to aid in the diagnosis of neuropsychological problems. Contemporary neuropsychological assessment typically involves one of two approaches. Some use a uniform group, or battery, of tests for all

patients. Others use a small subset of tests initially and then, based on the results of these initial tests, use additional tests to resolve and answer the referral questions. Some of the more popular neuropsychological test batteries include the Halstead-Reitan (Reitan, 1969) and the Luria-Nebraska Neuropsychological Battery (Golden, Purisch, & Hammeke, 1985). The field of neuropsychology is becoming increasingly sophisticated. Many neuropsychological tests are now computer administered, more attention is being directed to identifying neuropsychological correlates of mental disorder, and test results are integral components of rehabilitation planning (Golden, Zillmer, & Spiers, 1992; Jones & Butters, 1991).

Finally, the rise and popularity of managed health care in the 1990s has had an impact on psychological assessment. Although we will discuss this trend in more detail in Chapter 3, it is worth highlighting here. Managed health care (including mental or behavioral health) developed in response to the rapidly increasing cost of health care. Third-party insurers (e.g., large companies) were attracted to managed health care because it controlled and reduced costs. Managed health care requires those who provide services to be more accountable and more efficient in service delivery. Clinical psychologists who are providers for various managed health-care plans have become increasingly interested in using reliable and valid psychological measures or tests that (a) aid in treatment planning by identifying and accurately assessing problematic symptoms, (b) are sensitive to any changes or improvements in client functioning as a result of treatment, and (c) are relatively brief.

A number of these assessment highlights are summarized in the timeline Significant Events in Assessment.

Interventions

The Beginnings (1850–1899)

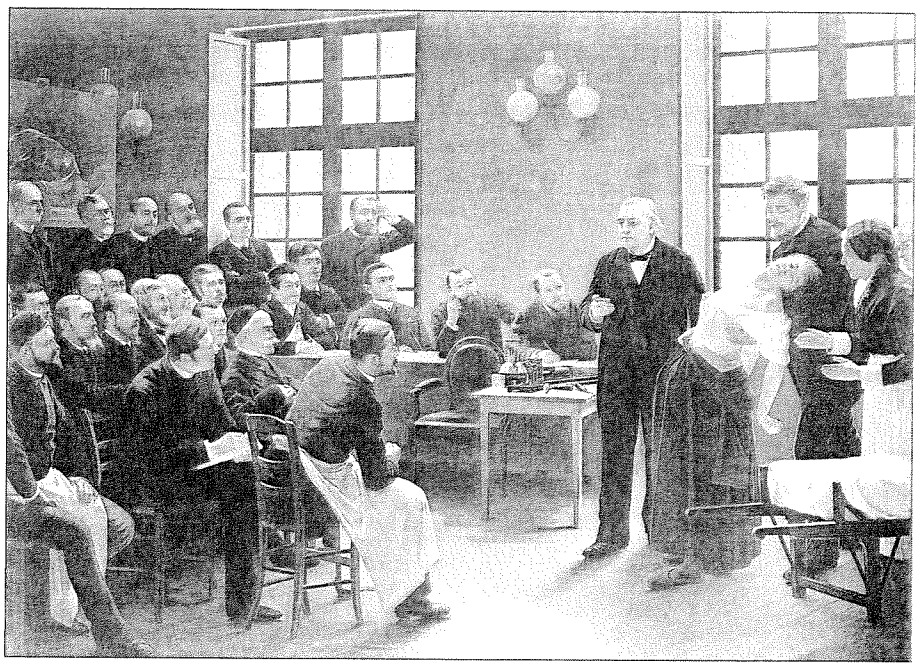
Emil Kraepelin's focus was on the classification of psychoses. But others were investigating new treatments for neurotic patients, such as suggestion and hypnosis. Specifically, Jean Charcot gained a widespread reputation for his investigations of patients with hysteria—patients with "physical symptoms" (e.g., blindness, paralysis) that did not seem to have an identifiable physical cause (Figure 2-2). He was a master of the dramatic clinical demonstration with hypnotized patients. As a matter of fact, he believed that only patients with hysteria could be hypnotized. However, he was probably investigating hypnosis rather than hysteria. Others, such as Hippolyte Bernheim and Pierre Janet, were critical of Charcot's work. Bernheim felt that the symptomatology of hysteria was nothing more than suggestibility. Janet, on the other hand, came to regard hysteria as a manifestation of a "split personality" and also as a kind of hereditary degeneration.

At about the same time, the momentous collaboration of Josef Breuer and Sigmund Freud began. In the early 1880s, Breuer was treating a young patient named "Anna O," who was diagnosed with hysteria. Anna O's treatment presented many challenges but also led to theoretical breakthroughs that would influence psychotherapy practice for years to come. Breuer discussed the case extensively with Freud, who became so interested that he went to Paris to learn all that Charcot could teach him about hysteria. To considerably shorten a long story, in 1895, Breuer and Freud published *Studies on Hysteria*. For a variety of reasons, the relationship between the two men subsequently became quite strained. But their collaboration served as the launching pad for *psychoanalysis*, the single most influential theoretical and treatment development in the history of psychiatry and clinical psychology.

The Advent of the Modern Era (1900–1919)

Reformers such as Clifford Beers have been important in the history of clinical psychology. Beers was hospitalized in the wake of severe depressions. While hospitalized, he passed into a manic phase and began recording his experi-

FIGURE 2-2 Jean Charcot demonstrated with a patient called "Wit." Although trained as a neurologist, Charcot employed a psychosocial approach to explaining hysteria.



ences in the hospital. When he was free of his manic-depressive symptoms, he was released. But this release did not weaken his resolve to write a book exposing the abuses in the hospital care of the mentally ill. He very much wanted to generate a public movement to rectify those abuses. In 1908, *A Mind That Found Itself* was published, and the mental hygiene movement in America was launched (Figure 2-3).

In 1900, shortly before Beers entered the hospital, Freud published *The Interpretation of Dreams*. With this event, the psychoanalytic movement was in full swing. Concepts such as the unconscious, the Oedipus complex, and the ego began their ascendance, and sexuality became the coin of the psychological realm.

Freud's ideas were by no means an overnight success. Recognition was slow in coming, but converts did begin to beat a path to his door. Alfred Adler, Carl Jung, and others began to take notice. Freud published other books, and the list of converts grew still longer, including A. A. Brill, Paul Federn, Otto Rank, Ernest Jones, Wilhelm Stekel, Sandor Ferenczi, and others.

Later in this chapter, we will note Lightner Witmer's establishment of the first psychological clinic. Also important was William Healy's establishment of a child guidance clinic in Chicago in 1909. This clinic used a team approach involving psychiatrists, social workers, and psychologists.

They directed their efforts toward what would now be labeled juvenile delinquents rather than toward the learning problems of children that had earlier attracted Witmer's attention. Healy's approach was greatly influenced by Freudian concepts and methods. Such an approach ultimately had the effect of shifting clinical psychology's work with children in the dynamic direction of Freud rather than into an educational framework.

FIGURE 2-3 Clifford Beers wrote *A Mind That Found Itself,* a chronical of his experiences while hospitalized as a mental patient. His efforts were instrumental in launching the mental hygiene movement.

In 1905, Joseph Pratt, an internist, and Elwood Worcester, a psychologist, began to use a method of supportive discussion among hospitalized mental patients. This was the forerunner of a variety of group therapy methods that gained prominence in the 1920s and 1930s.

Between the Wars (1920–1939)

The psychoanalysis of the early 20th century was largely devoted to the treatment of adults and was practiced almost exclusively by analysts whose basic training was in medicine. Freud, however, argued that psychoanalysts did not need medical training. Despite Freud's protestations (Freud, 1926/1959), the medical profession claimed exclusive rights to psychoanalytic therapy and in so doing made the subsequent entry of psychologists into the therapy enterprise quite difficult.

The eventual entry of psychologists into therapeutic activities was a natural outgrowth of their early work with children in various *guidance clinics.* At first, that work was largely confined to the evaluation of children's intellectual abilities, and this, of course, involved consultations with parents and teachers. But it is hard to separate intellectual functioning and school success from the larger psychological aspects of behavior. As a result, it was only natural that psychologists should begin to offer advice and make recommendations beyond the narrow analysis of abilities.

As psychologists looked for psychological principles to aid in their efforts, the work of both Freud and Alfred Adler came to their attention. In particular, they were impressed by Adler's work, which had a more commonsense ring than Freud's. Moreover, Freud's emphasis seemed to lie with adults and with the sexual antecedents of their problems, whereas Adler's deemphasis of the role of sexuality in a person's psychological economy and his concomitant emphasis on the structure of family relationships seemed much more congenial to American mental health professionals in the field. By the early 1930s, Adler's (1930) ideas were firmly ensconced in those American clinics that dealt with children's problems.

A second trend that influenced early work with children—*play therapy*—was more directly derived from traditional Freudian principles. Play therapy is essentially a technique that relies on the curative powers of the release of anxiety or hostility through expressive play. In 1928, Anna Freud, the distinguished daughter of Sigmund Freud, described a method of play therapy derived from psychoanalytic principles.

Group therapy also began to attract attention. By the early 1930s, the works of both J. L. Moreno and S. R. Slavson were having an impact. Another precursor of things to come was the technique of "passive therapy" described by Frederick Allen (1934). In this approach, one can see some of the first stirrings of what would become

client-centered therapy. But there were other straws in the wind too. In 1920, John Watson described the famous case of Albert and the white rat, in which a young boy was conditioned to develop a neurotic-like fear of white, furry objects (Watson & Rayner, 1920). A few years later, Mary Cover Jones (1924) showed how such fears could be removed through conditioning. Still later, J. Levy (1938) described "relationship therapy." These latter three events marked the beginnings of *behavior therapy,* a very popular and influential group of therapeutic methods used today.

World War II and Beyond (1940–Present)

World War II not only required enormous numbers of men, but it also contributed to the emotional difficulties that many of them developed. The military physicians and psychiatrists were too few in number to cope with the epidemic of these problems. As a result, psychologists began to fill the mental health breach. At first, the role of psychologists was ancillary and often involved mainly group psychotherapy. But increasingly, they began to provide individual psychotherapy, performing well in both the short-term goal of returning men to combat and in the longer term goal of rehabilitation. Psychologists' successful performance of these activities, along with their already demonstrated research and testing skills, produced a gradually increasing acceptance of psychologists as mental health professionals.

This wartime experience whetted the appetites of psychologists for greater responsibility in the mental health field. It is uncertain whether this increasing focus on psychotherapy stemmed from a desire to gain greater professional responsibility, an awareness that they possessed the skills to perform mental health tasks, an embryonic disenchantment with the ultimate utility of diagnostic work, or some combination of the three. However, the stage had been set.

An additional contributing factor to this chain of events was an outgrowth of the turmoil in Europe in the 1930s. The pressures of Nazi tyranny forced many European psychiatrists and psychologists to leave their homelands, and many of them ultimately settled in the United States. Through professional meetings, lectures, and other gatherings, the ideas of the Freudian movement generated excitement and also gained increasing credence in psychology. Partly as a result, clinical psychologists began to reduce their emphasis on the assessment of intelligence, ability testing, and the measurement of cognitive dysfunction and became more interested in personality development and its description.

As intelligence testing receded in importance, psychotherapy and personality theory began to move into the foreground. A large part of the activity in these areas was psychoanalytic in character. In 1946, Alexander and French published an influential book on briefer psychoanalytic interventions. However, in 1950, John Dollard and Neal Miller published their book *Personality and Psychotherapy,* which was a seminal attempt to translate the psychoanalysis of Freud into the language of learning theory. Indeed, psychoanalysis was such a dominant force of the time that when Carl Rogers published *Client-Centered Therapy* in 1951, his was the first major alternative to psychoanalytic therapy up to that point. Rogers' book was an enormously significant development that had extensive repercussions in the world of psychotherapy and research.

Newer forms of therapy were beginning to proliferate. For example, Perls introduced Gestalt therapy (Perls, Hefferline, & Goodman, 1951), and Frankl (1953) talked about logotherapy and its relationship to existential theory. In 1958, Ackerman described family therapy, and in 1962, Ellis explained his rational-emotive therapy. About the same time, along came Berne's (1961) transactional analysis, or TA. Therapy had surely become a growth industry. There was no better indication of the importance of psychotherapy in the professional lives of clinicians than the effect of Eysenck's (1952) critique of therapy. His scathing report on the ineffectiveness of psychotherapy alarmed many and inspired others to conduct research designed to prove him wrong.

However, psychotherapy was not the whole story. The behaviorists were beginning to develop what they regarded as a more "hardheaded"

brand of therapy. Andrew Salter (1949) wrote *Conditioned Reflex Therapy,* a pioneering work in what later evolved into desensitization methods. In 1953, B. F. Skinner furthered the behavioral therapy cause when he outlined the application of operant principles to therapeutic and social interventions. Then in 1958, Joseph Wolpe introduced systematic desensitization, a technique based on conditioning principles; the behavior therapy movement was now more firmly entrenched than ever. Albert Bandura (1969) set the stage for the cognitive-behavioral movement by demonstrating how behavior could be modified through the observation of others, or modeling.

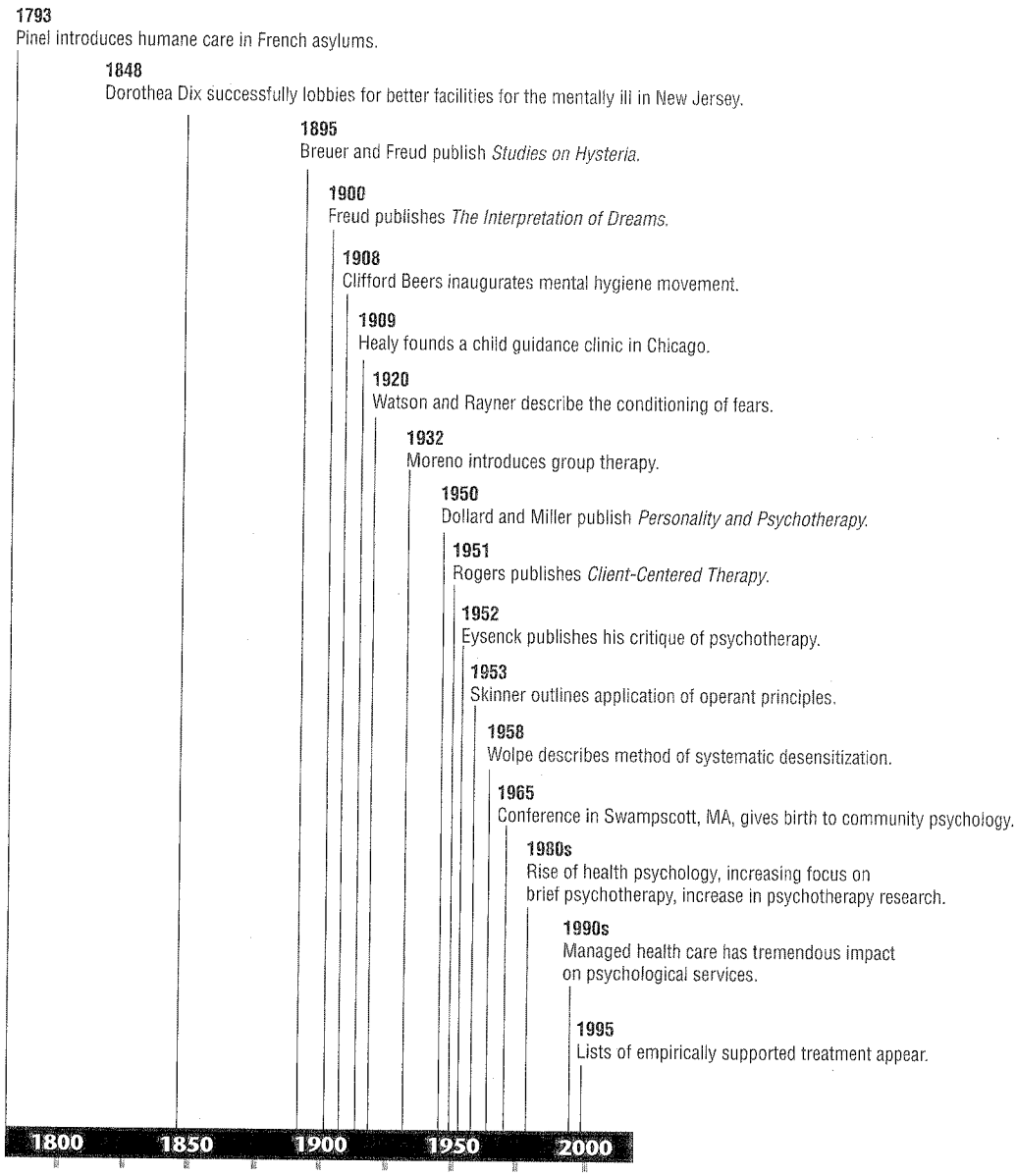
Whereas psychoanalysis and psychodynamic psychotherapy were previously the dominant forces, behavior therapy was now gaining in popularity among clinical psychologists. Its appeal stemmed from its focus on observable (and measurable) behavior, the shorter length of treatment required, and the emphasis on the empirical evaluation of treatment outcome. Behavior therapy helped stimulate the growth of psychotherapy research. Previously, only a select number of academics conducted studies of treatment efficacy. We now see many researchers and practitioners who use empirical methods to investigate the effectiveness of various treatment techniques.

Several other trends in intervention are noteworthy. First, the number of treatments employed by clinical psychologists has grown tremendously over the years. These range from cognitive-behavioral approaches that have empirical support to "trendier" approaches like "inner-child therapy" that have no empirical support. Some have estimated the number of therapies available at well over 400. Fortunately, not all of these are "therapies of the month," and many have empirical support. Perhaps because of this startling array of therapeutic orientations and treatment choices, many clinical psychologists refer to themselves as *eclectics.* These clinicians employ the techniques of more than one theoretical orientation, basing their selection on the particular problems presented by the individual client or patient. At the same time, many clinical psychologists are interested in integrating various approaches into one therapeutic modality, as well as identifying common factors that underlie different approaches to treatment (J. D. Frank, 1971).

Second, *brief* or *time-effective therapy* (Budman & Gurman, 1988) is becoming a preferred mode of psychotherapeutic intervention for several reasons. Many individuals cannot afford years of psychotherapy. Briefer forms of therapy have been shown to be equally as effective, if not more effective, than traditional psychotherapy. Further, managed care companies that control reimbursement for mental health treatment are often unwilling to reimburse clinicians for more than a handful of sessions. Along with the development of brief forms of therapy, *"manualized" forms of treatment* have been introduced into clinical work (e.g., Beck, Rush, Shaw, & Emery, 1979; Strupp & Binder, 1984). These manuals are useful for clinicians because they outline treatment goals for each session as well as techniques to be used, and typically, the treatment "package" can be implemented and completed in 10 to 15 sessions or less. Further, they assist research aimed at determining the efficacy or effectiveness of psychological interventions. Currently, treatment manuals are available for a wide range of psychological problems, including depression, anxiety disorders, and personality disorders. Many of these treatments will be highlighted throughout this book.

Third, by the 1950s, some clinicians had begun to be disenchanted with therapy methods that dealt with one patient at a time (or even 10 patients at a time, as in group therapy). They sought a more "preventive" approach. Their search culminated in the rise of *community psychology* in the 1960s and *health psychology* in the 1980s. A growing number of clinical psychologists provide services related to the prevention of health problems, mental health problems, and injury. The area of prevention is often associated with health psychology and will increasingly be

TIMELINE: Significant Events in Intervention



in the spotlight in years to come as psychology is called upon by primary care physicians and managed care companies.

Finally, starting in 1995, lists of "empirically supported treatments" have been widely disseminated among clinical psychologists (e.g., Task Force on Promotion and Dissemination of Psychological Procedures, 1995). The original list and subsequently revised lists have identified those interventions for commonly encountered clinical

problems that have garnered empirical support through multiple outcome studies. We will discuss many of these interventions in later chapters.

Recently, two important events occurred that will surely affect the field of intervention in clinical psychology. Although we will discuss these events in more detail in the next chapter, it is worth noting them here. First, in 1995, the American Psychological Association officially endorsed the pursuit of prescription privileges for psychologists. Then in 2002, New Mexico became the first state to enact a law authorizing properly trained psychologists to prescribe psychotropic medications to patients or clients. Reportedly, more states may follow suit. Thus, it seems reasonable to expect that clinical psychology interventions will no longer be limited to "talk therapy"; practitioners are likely to complete the necessary training to obtain prescription privileges and use medications in their practice.

A summary of the major historical events relevant to interventions is presented in the timeline Significant Events in Intervention.

Research

The Beginnings (1850–1899)

The academic research tradition in psychology owes much to the work of two men. Wilhelm Wundt, a German, is usually credited with establishing the first formal psychological laboratory in Leipzig in 1879. In that same decade, an American, William James, also established a laboratory, and in 1890, he published his classic text, *Principles of Psychology.* The works of both these men exemplify the scholarly tradition. Their influence is also clearly discernible in the scientist-practitioner model that has served the field of clinical psychology for so many years.

The Advent of the Modern Era (1900–1919)

During this period, Ivan Pavlov was lecturing on the conditioned reflex. His work on conditioning left an important legacy for clinical psychology. The notion of classical conditioning has become a central part of theory and research while also playing a significant role in a variety of therapeutic methods. Another important development was research on intelligence testing. In 1905, Binet and Simon offered some evidence for the validity of their new test, and in 1916, Terman's research on the Binet-Simon test appeared. This was also the era of the development of the Army Alpha and Beta tests, described earlier.

Between the Wars (1920–1939)

Clinical research was still in its infancy. Much of the noteworthy work was in the area of test development—for example, the 1939 publication of the Wechsler-Bellevue test and all the personality testing work of the 1930s. On the academic research scene, behaviorism and Gestalt psychology were prominent. Behaviorism taught clinicians the power of conditioning in the development and treatment of behavior disorders.

Gestalt psychology emphasized the importance of understanding that patients' unique perceptions contribute to their problems.

World War II and Beyond (1940–Present)

By the mid-1960s, diagnosis and assessment had become less important for many clinicians. However, in the 1950s, you would hardly have predicted it. The journals were full of research studies dealing with both intelligence testing and personality assessment. Study after study dealt with various aspects of the Stanford-Binet and the Wechsler scales. Research on their validity and reliability, their use with various diagnostic groups, short forms, and implications for personality appeared in waves. The story was similar for projective tests. Literally hundreds of studies dealing with the Rorschach and TAT were published. Many of these studies also focused on issues of reliability and validity. Some observers attribute part of the subsequent decline in projective testing to the many negative validity studies that appeared during this time.

Another very important research development during these years was the emergence of studies on the process and effectiveness of psy-

chotherapy. As noted previously, Eysenck's critique sent clinicians scrambling to shore up psychotherapy's image through solid research evidence. One of the real pioneers in therapy research was Carl Rogers (1951). His use of recordings to study the process of therapy opened windows to an activity that had long been shrouded in mystery. Rogers and Dymond (1954) reported controlled research findings on the counseling process.

Another research landmark of this era was the publication of Julian Rotter's *Social Learning and Clinical Psychology* in 1954. It presented not only a social learning theory but also a series of controlled studies that provided an empirical foundation for the theory. Research on the theory's implications for assessment and therapy was also included. The work provided a solid foundation upon which subsequent social learning theorists could build.

The 1950s also witnessed the explicit beginnings of the more behaviorally oriented forms of intervention. Joseph Wolpe's research in South Africa on animal and human learning convinced him that his work was relevant to human emotional problems and led him to develop the method of *systematic desensitization* (Wolpe, 1958). This behavioral method relies neither on insight, thought to be so necessary by the psychoanalysts, nor on growth potential, considered equally necessary by the client-centered school of therapy. Arnold Lazarus and Stanley Rachman also helped facilitate this movement. Another influential figure in the behavioral research movement was Hans Eysenck, who coined the term "behavior therapy" and wrote an important book on the topic in 1960.

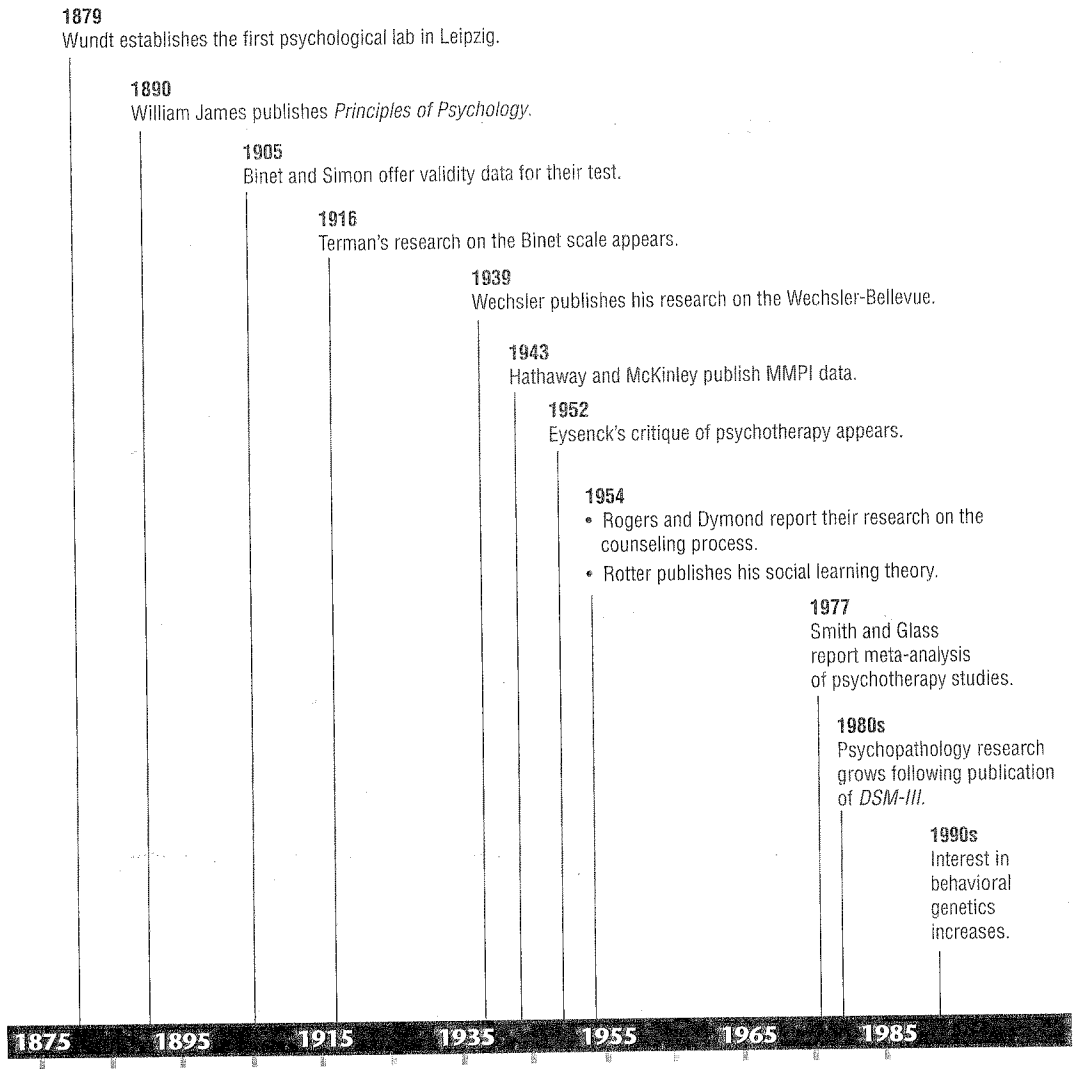
As noted earlier, beginning in the 1950s, the effectiveness of psychotherapy was being questioned. However, in 1977, Mary Smith and Gene Glass published a survey that supported the efficacy of therapy. This work laid the basis for a series of studies that has helped us better understand the way therapeutic methods affect patients. As noted previously, the field of *psychotherapy research* continues to grow to this day.

Other areas of research that have grown tremendously are diagnosis and classification as well as psychological testing and measurement. The publication of *DSM-III* (American Psychiatric Association, 1980) spurred an explosion of research aimed at evaluating the reliability, validity, and utility of specific criteria listed for the mental disorders included in this manual. Both psychiatry and psychology journals published numerous studies on the *DSM-III* criteria for syndromes such as schizophrenia, major depression, and antisocial personality disorder. In addition, more clinical psychologists began conducting research aimed at identifying the *etiological* (causal) factors associated with the development of various mental disorders. The factors investigated ranged from genetic predispositions to traumatic childhood events such as physical or sexual abuse.

Published research on psychological inventories, interviews, and rating scales has also increased. With the proliferation of psychological instruments available to researchers and clinicians, the reliability and validity of these measures need to be evaluated empirically. Symptomatic of the growth of this research area is the "splitting" of a major clinical psychology journal, the *Journal of Consulting and Clinical Psychology (JCCP)*, in two. Now, in addition to *JCCP*, we have the journal *Psychological Assessment*, the primary outlet for research on psychological tests and measures used by clinical psychologists. It is important to note, however, that the research of clinical psychologists is published in many other high-quality journals besides these two. The following list indicates the range of journals that publish research important to the field:

Journal of Consulting and Clinical Psychology
Psychological Assessment
Clinical Psychology: Science and Practice
Journal of Abnormal Psychology
Psychological Bulletin
Behavior Therapy
Psychological Science
American Journal of Psychiatry
Archives of General Psychiatry
Professional Psychology: Research and Practice
Clinical Psychology Review

TIMELINE: Significant Events in Research



Finally, the decade of the 1990s has witnessed an increasing amount of interest among clinical psychologists in the field of behavioral genetics. Behavioral genetics is a research specialty in which both genetic and environmental influences on the development of behavior are evaluated. Behavioral geneticists have investigated these influences in a wide range of behaviors and individual differences, including intelligence, personality, and psychopathology. We will review this important field in later chapters.

Because research is such an important part of all clinical psychology, we will be discussing research methods, research on particular topics, and the historical context of research in these areas throughout this book. Many of the research highlights are mentioned in the timeline Significant Events in Research.

The Profession

The Beginnings (1850–1899)

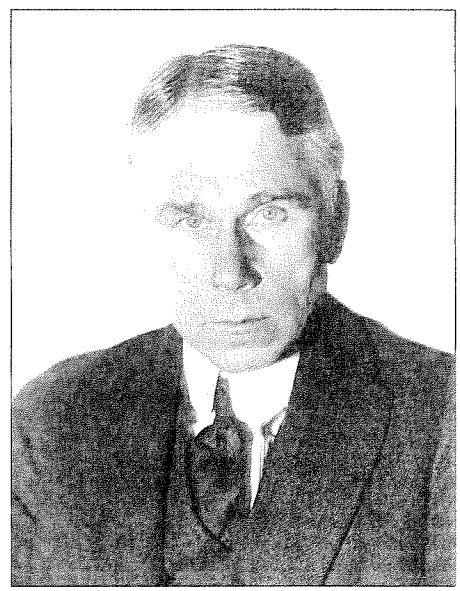
Two events of great significance in the development of clinical psychology as a profession occurred just as the 19th century was winding down. The first was the founding of the American Psychological Association (APA) in 1892, with G. Stanley Hall as its first president. Although the membership of the association was still fewer than 100 by the close of the 19th century, the profession had truly begun.

The birth of clinical psychology was not far behind. In 1896, Lightner Witmer established the first psychological clinic at the University of Pennsylvania. Many would date the real beginning of clinical psychology from this time (McReynolds, 1996) (Figure 2-4).

Witmer's clinic was devoted to the treatment of children who were experiencing learning problems or who were disruptive in the classroom. In the first issue of *The Psychological Clinic* in 1907, Witmer wrote:

> Children from the public schools of Philadelphia and adjacent cities have been brought to the laboratory by parents or teachers; these children had made themselves conspicuous because of an inability to progress in school work as rapidly as other children, or because of moral defects which rendered them difficult to manage under ordinary discipline.
>
> When brought to the psychological clinic, such children are given a physical and mental examination; if the result of this examination shows it to be desirable, they are then sent to specialists for the eye or ear, for the nose and throat, and for nervous diseases, one or all, as each case may require. The result of this conjoint medical and psychological examination is a diagnosis of the child's mental and physical condition and the recommendation of appropriate medical and pedagogical treatment. (Witmer, 1907, p. 1)

FIGURE 2-4 Lightner Witmer's development of the first psychological clinic began with the referral of a boy who showed an odd spelling problem. It ended by stimulating the establishment of a profession that was different from both education and medicine.



Brown Brothers

In many ways, Witmer's influence on the field was historical rather than substantive. That is, he got the profession under way but really added little in the way of new theories or methods. It was he who named the field "clinical psychology," and he was the first to teach a specific course in clinical psychology. Further, it was Witmer who in 1907 founded the first journal in clinical psychology, *The Psychological Clinic*—a journal that he edited and contributed articles to until it ceased publication in 1935. Although the manner in which clinical psychologists do things today may not have been much influenced by Witmer, the fact that they are doing them at all is due in no small measure to his efforts and foresight (McReynolds, 1987, 1996). Box 2-1 summarizes Witmer's seminal contributions to the field.

BOX 2-1

Lightner Witmer: The Founder of Clinical Psychology

Lightner Witmer (1867–1958) is credited with founding the field of clinical psychology. His contributions to the field include the following:

- In 1896, he established the first "psychological" clinic.
- In 1907, he proposed a new profession, clinical psychology.
- He served as founder and editor of the first journal in the field, *The Psychological Clinic.*
- He developed the first training program in clinical psychology (McReynolds, 1996).

In addition, Witmer's work influenced and anticipated future developments in clinical psychology, including an emphasis on children's academic problems, the use of active clinical interventions to improve individuals' lives, and collaboration with other professionals (e.g., physicians) in providing treatment (Routh, 1996).

The Advent of the Modern Era (1900–1919)

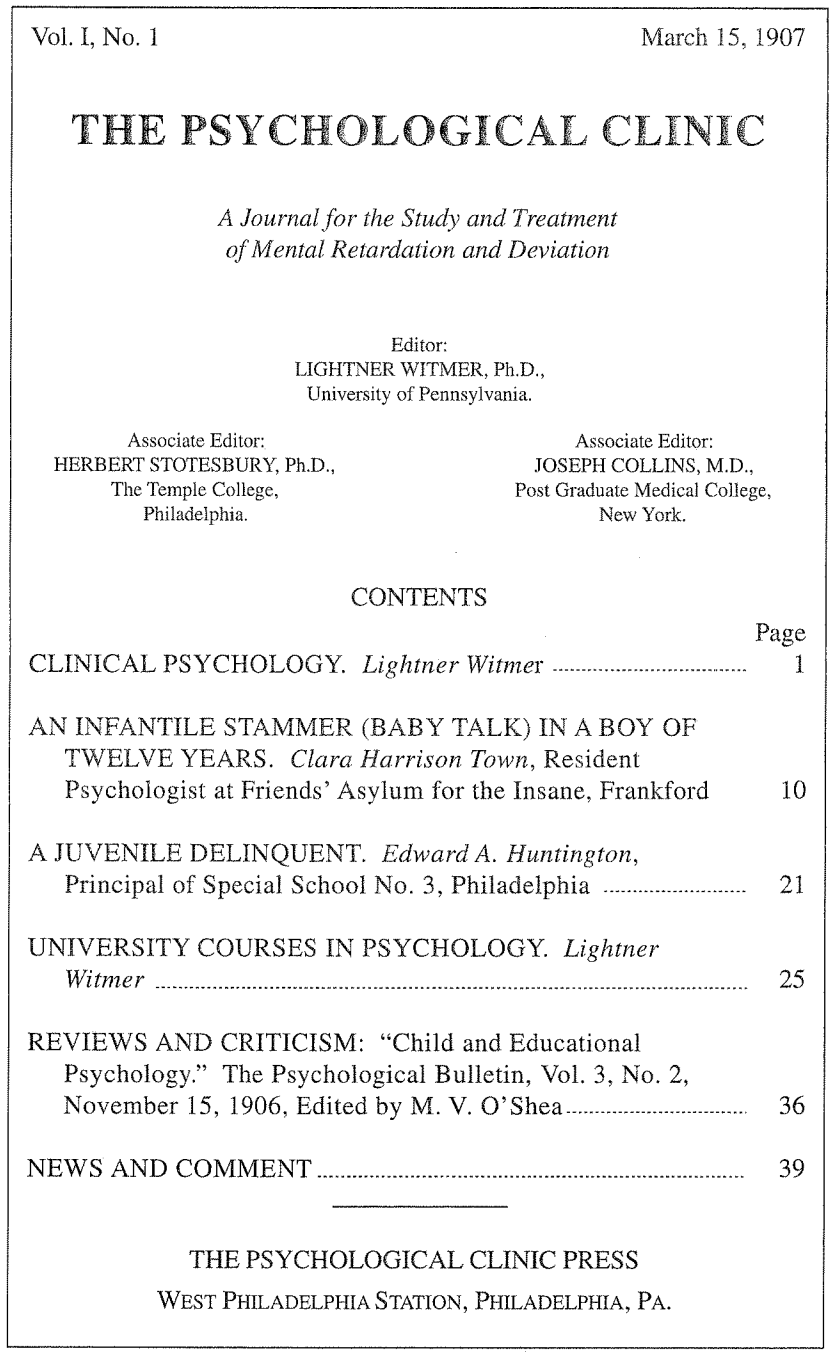
In the first decade of the 20th century, only a very small number of psychologists could be found employed outside the universities. In 1906, Morton Prince began publishing the *Journal of Abnormal Psychology,* and in 1907, Witmer began publication of *The Psychological Clinic* (see Figure 2-5). With two journals of their own, applied clinicians could now begin to form their identity. This identity was further reinforced when, in 1909, Healy established the juvenile Psychopathic Institute in Chicago. The Iowa Psychological Clinic had been started in 1908, the same year that Goddard began offering psychological internships at the Vineland Training School in New Jersey. With its own journals, clinics, and internships, the profession of clinical psychology was beginning to take shape.

By 1910, there were 222 APA members, paying annual dues of $1. (In 2003, membership dues were $236, not including an additional $110 special assessment fee for licensed healthcare psychologists!) However, the focus of APA was on psychology as a science, not as a profession. At the same time, the public schools of the day were beginning to clamor for testing services, and universities were beginning to respond with testing courses and studies of those with cognitive limitations. Finally, in 1919, the first Section of Clinical Psychology was created within the APA. Meanwhile, an ever-increasing number of psychological clinics were being established (e.g., the organization by Healy in 1917 of the Judge Baker Foundation in Boston). However, World War I and the growth of the group testing movement did as much as anything to spur the development of the new profession.

Between the Wars (1920–1939)

The APA had long proclaimed that its mission was to further psychology as a science. However, by the close of the 1920s, many clinically oriented psychologists were becoming uneasy and increasingly sought to gain recognition of their unique roles and interests from APA. In 1931, the Clinical Section of APA appointed a committee on training standards, and in 1935, the APA Committee on Standards of Training defined clinical psychology as "that art and technology which deals with the adjustment problems of

FIGURE 2-5 Cover of the first issue of *The Psychological Clinic.*



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THE PSYCHOLOGICAL CLINIC

A Journal for the Study and Treatment of Mental Retardation and Deviation

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THE PSYCHOLOGICAL CLINIC PRESS
WEST PHILADELPHIA STATION, PHILADELPHIA, PA.

human beings" (Reisman, 1976, p. 250). It is doubtful whether many clinicians even today would reject this definition.

In 1936, Louttit published the first clinical psychology text, and in 1937, the *Journal of Consulting Psychology* was founded. Still published today as the *Journal of Consulting and Clinical Psychology (JCCP)*, it serves as a major publication outlet for the research of many clinicians. Such events signaled real growth for clinical psychology as a profession. Another trend also attested to the development of the field: Psychological tests were beginning to become financial winners. James McKeen Cattell founded the Psychological Corporation in 1921 to develop and market psychological tests (particularly those of interest to industry). The proceeds were used to stimulate psychological research. Thus, money began to invade the ivory tower. For example, a $75,000 gift enabled Morton Prince to establish the Harvard Psychological Clinic in 1927. Nevertheless, the clinical psychologists of the day were quite different in terms of both activities and training from those of today.

World War II and Beyond (1940–1969)

The process of absorbing large numbers of soldiers into the U.S. military in the early 1940s generated many needs. One such need was for a large-scale screening program to weed out those who were unfit for military service. Psychologists had already begun to develop the rudiments of a testing technology that would assist in this task, and they also had expertise in research methods. These skills set them apart from their psychiatric colleagues. Both their technology and their research orientation served psychologists well in the establishment of a professional identity. More than 1,700 psychologists served in World War II, and they returned to civilian life with increased confidence in their abilities and a determination to build a profession.

All of this was very important in affecting the federal government's response to the mental health problems facing the United States after World War II. To the Veterans Administration (VA) fell the enormous burden of providing care and rehabilitation for the thousands upon thousands of men and women who had suffered some form of emotional trauma from their military service. Without a marked increase in mental health professionals, there was no way that the VA could fulfill its mission and cope with the rising tide of patients that swept into its clinics and hospitals. The VA's solution was to increase the availability of mental health professionals by providing financial support for their training.

In the case of clinical psychology, the VA provided financially attractive internships for graduate students in approved university Ph.D. programs. Although not required to do so, many of these students chose to remain with the VA after completing their training. Through its programs, the VA played a chief role in upgrading and building the profession of clinical psychology. Its willingness to hire clinicians at salaries higher than could generally be obtained elsewhere raised the entire pay scale of the profession. Its need to deal with the psychological problems of adults resulted in a major shift in clinical psychologists' services from children to adults. At the same time, the VA came to expect clinical psychologists to conduct individual and group psychotherapy along with their accustomed psychodiagnostic activities. They also continued to serve in their familiar capacity as the research experts on mental health teams. When, in 1946, the VA initiated its program to train clinical psychologists, clinical training had secured a firm financial foundation. By 1949, 42 schools were offering the doctorate in clinical psychology, and large numbers of high-quality students were applying. The profession had attained public visibility.

The VA was not the only federal agency to promote the rise of clinical psychology. The aftermath of the war and the general increase in government activity also led to an attempt to ameliorate some of the mental health problems in the nation as a whole. The U.S. Public Health Service and the National Institute of Mental

Health initiated support of clinical psychology graduate students working toward the Ph.D. and sponsored research and training programs designed to provide answers to the nation's mental health problems.

Further evidence of professional growth was the publication of the first *American Psychologist* in 1946. In 1945, Connecticut became the first state to pass a certification law for psychologists. During the following year, the American Board of Examiners in Professional Psychology (ABEPP) was established to certify the professional competence of clinicians holding the Ph.D. In 1949, the Educational Testing Service was started. The APA was now asserting that psychotherapy was an integral function of clinical psychologists—notwithstanding the opposition from the psychiatric profession. The APA was also assuming a more activist role. It was beginning to make recommendations for the training of clinical psychologists and also to certify clinical training programs. In 1953, it published *Ethical Standards,* a landmark achievement in the codification of ethical behavior for psychologists and a great step forward in the protection of the public. By the beginning of the 1950s, the APA could claim more than 1,000 members in its Clinical Division. In just a few years after World War II, the profession had made enormous strides.

In 1949, a conference on graduate education in clinical psychology was held in Boulder, Colorado. The Boulder Conference was a truly significant event in clinical psychology because it explicated the *scientist-practitioner model* for training clinical psychologists that has served as *the* principal guideline for training ever since. In succinct terms, this model asserts (a) clinical psychologists shall pursue their training in university departments; (b) they shall be trained as psychologists first and clinicians second; (c) they shall be required to serve a clinical internship; (d) they shall achieve competence in diagnosis, psychotherapy, and research; and (e) the culmination of their training shall be the Ph.D. degree, which involves an original research contribution to the field. By and large, this still serves as the training model, even though the scientist-practitioner model has always had its critics.

The 1950s witnessed a marked growth in the psychological profession. The membership of APA rose from 7,250 in 1950 to 16,644 in 1959—a phenomenal increase. In approximately the same period, federal research grants and contracts for psychological research rose from $11 million to more than $31 million.

The Growth of a Profession (1970–Present)

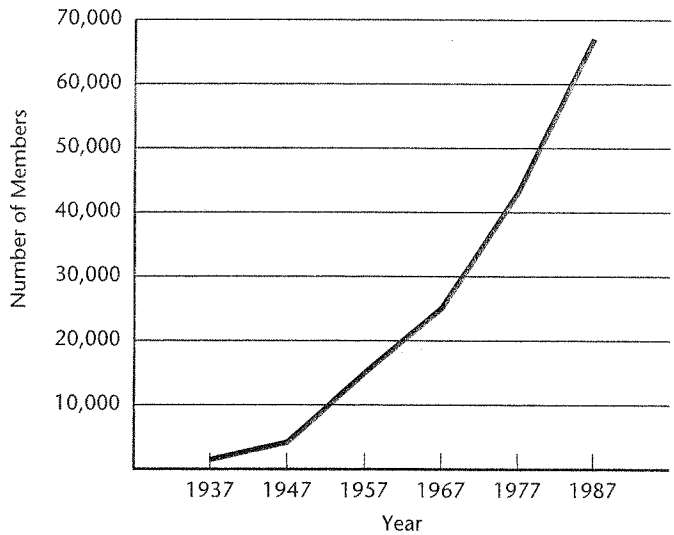
In the areas of assessment, intervention, and research, clinical psychology has become increasingly behavioral since the mid-1960s. The focus has shifted from a search for the traits or internal factors that lead people into a psychopathological condition to an analysis of the situational factors that control their behavior. In the late 1960s, the road to changing undesirable behavior began swerving sharply from psychotherapy (and the insight it was designed to produce) to conditioning and altered reinforcement contingencies. Research journals were full of articles describing new objective methods of assessing behavior and novel behavioral approaches to the treatment of everything from alcoholism, sexual dysfunctions, and lack of assertiveness to obesity, smoking, and loneliness. The key to everything lay not in patients' thoughts but in their behavior.

Some, of course, began to suspect that all this was an overreaction. Were traits really fictions that had no utility? Could behavioral analyses and methods address and cure everything? Many thought not, and by the mid-1970s, cognition had begun to creep back onto the scene. People now began talking about "cognitive behavior methods" (Goldfried & Davison, 1976). The cognitive-behavioral orientation to treatment is now among the most common.

At the same time, the field of community psychology, which had seemed poised in the 1960s to revolutionize clinical psychology, began to falter. To many, its promise seemed unfulfilled. Then in the 1980s, the preventive

FIGURE 2-6 APA membership from 1937 to 1987

Adopted from "Report of the Executive Vice-president: 1987," by L. D. Goodstein, American Psychologist, *1988, 43, 491–498. Copyright 1988 by the American Psychological Association. Reprinted by permission.*



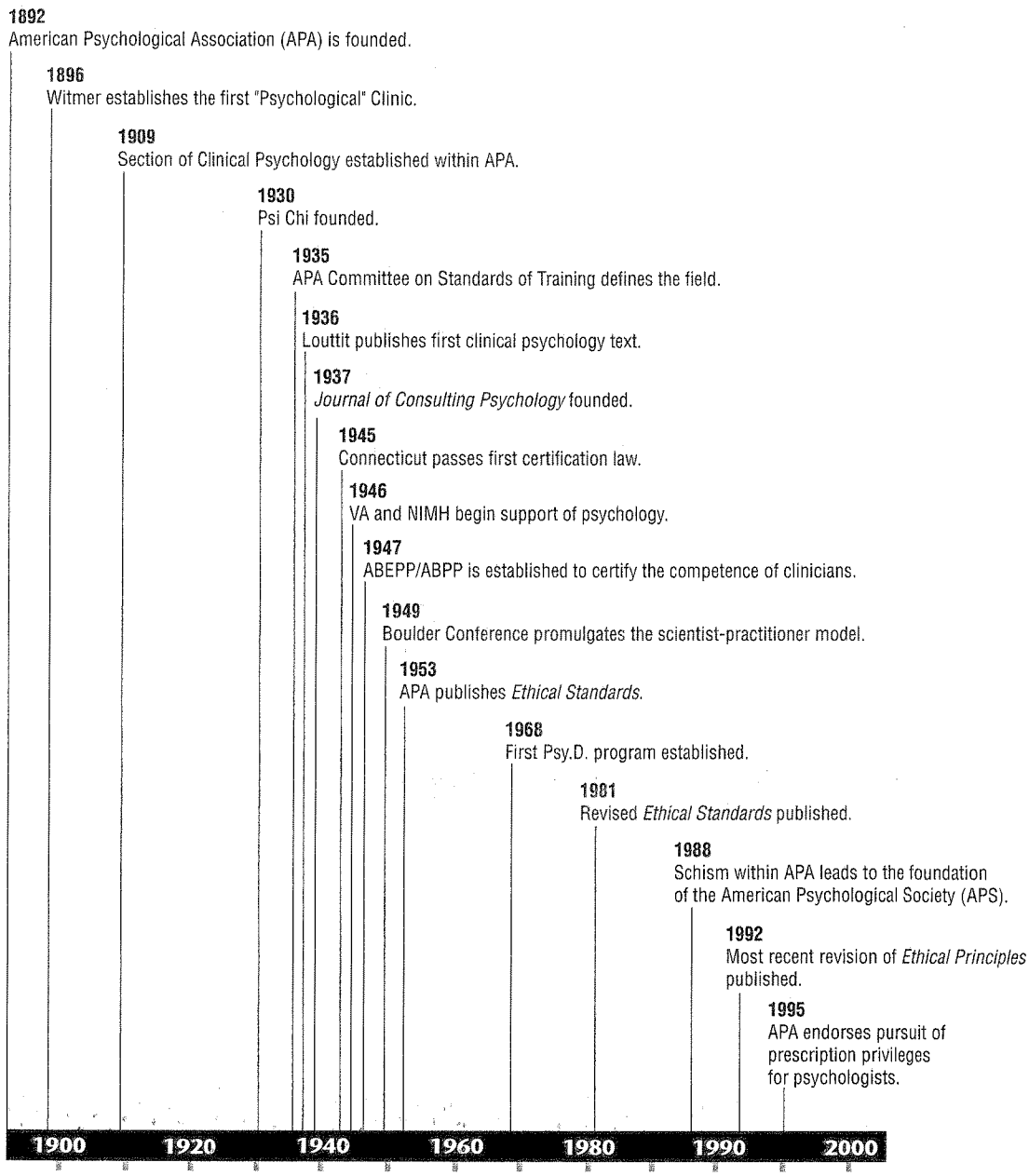
focus reappeared with the development of the field of health psychology. All these concepts, methods, and trends of the past 35 years constitute the major thrusts of this book and will be covered in detail in the ensuing chapters.

The 1970s and 1980s witnessed still further growth in the profession. In 1970, there were 81 fully approved graduate training programs in clinical psychology and well over 12,000 clinicians. As for APA itself, in 1892, there had been 42 members; by 1987, there were almost 67,000. This phenomenal growth is shown in Figure 2-6. Currently, membership in the APA is over 80,000, and the operating budget is over $83 million. Also, the Division of Clinical Psychology (Division 12; now called the Society of Clinical Psychology) is the largest single unit in the APA. All 50 states, the District of Columbia, Puerto Rico, and several Canadian provinces either license or certify psychologists. Many clinical psychologists now have hospital privileges, and most can be reimbursed for their services by insurance and managed care companies. There has also been an increase in the number of clinical psychology graduate programs. Today, there are more than 200 doctoral training programs in clinical psychology with full APA approval.

The 1988 Schism

Within the APA, there have always been conflicts, sometimes acrimonious, between clinicians and their scientific counterparts. Often, these conflicts placed the scientist-practitioner squarely in the middle. By 1988, the academic-scientific wing of the APA seems to have concluded that APA was under the control of the practitioners, who were using their power to promote their own interests. Scientific interests, they said, were being replaced by goals that were essentially guildlike. The APA seemed to be preoccupied with such professional issues as writing prescriptions, hospital privileges, reimbursement questions, licensing, legal actions against psychiatry, and so on. In short, many had come to feel that the APA was no longer responsive to the academic-scientific needs of a significant number of its members. Indeed, former APA president Janet Spence charged that 90% of APA council

TIMELINE: Significant Events in the Profession of Clinical Psychology



meetings were taken up by the professional interests of practicing clinicians.

Matters seemed to come to a head when, in 1988, a plan to reorganize APA so as to help heal the growing schism between the clinical wing and the academic-scientific wing failed by a 2-to-1 vote of the membership. The response of those disenchanted with the APA was to form a new, separate organization. The *American Psychological Society (APS)* was founded in 1988, led by 22 former APA presidents who became founding members. The initial advisory board of APS read like a

scientific "Who's Who." The first APS convention was held in June 1988 and by most accounts was a resounding success. This organization now has a newsletter, *The Observer,* a monthly employment bulletin, and three scientific journals, *Psychological Science, Psychological Science in the Public Interest,* and *Current Directions in Psychological Science.* Today, the total APS membership exceeds 13,000. Approximately 13% of APS members identify themselves as clinical, counseling, or school psychologists. The professed goals of this new organization are to:

- Advance the discipline of psychology
- Preserve the scientific base of psychology
- Promote public understanding of psychological science and its applications
- Enhance the quality of education
- Encourage the "giving away" of psychology in the public interest

Many on both sides of the APA-APS split feel the break was tragic. They believe that it was unfortunate for both sides—that what the field needs is greater integration of the science of psychology and its practice. Unfortunately, the split may produce even less integration than now exists. Many believe that it will only hasten the day when APA becomes unabashedly a guild organization. Of course, many in the academic-scientist group and many who are traditional scientist-practitioners now belong to both APA and APS. Many scientific psychologists are exhilarated over the quick growth of APS. In any case, let us hope that both APA and APS remember their larger obligations to the public good.

As mentioned earlier, two recent landmark events will influence the profession of clinical psychology. In 1995, the APA officially endorsed the pursuit of prescription privileges for psychologists, and in 2002, New Mexico became the first state to enact a law allowing properly trained psychologists to prescribe medications for mental health conditions. These events will affect not only the practice of clinical psychology but also training and research.

Finally, in 2002, the APA published a new version of the Ethical Principles of Psychologists and Code of Conduct that took effect on June 1, 2003. Some of the highlights of these professional developments are summarized in the timeline Significant Events in the Profession of Clinical Psychology.

Today, the field of clinical psychology is challenged by a host of professional issues. In Chapter 3, we will discuss several of these in some detail. Briefly, they include the question of the optimal training model for contemporary clinical psychologists, the impact of the health-care revolution and managed care on clinicians, and the current push for prescription privileges for clinical psychology. The way that these issues are resolved will greatly affect the field of clinical psychology for years to come.

Chapter Summary

Clinical psychology has changed, and it will certainly change even more. Witmer would scarcely recognize it. G. Stanley Hall, APA's first president, would doubtless be amazed at the things APA and APS are doing. However, although training and practice are in a state of flux, certain constants remain. Clinical psychologists are still involved in assessment and treatment. They still have research contributions to make, and they are still concerned with their professional development. The goal that binds clinical psychologists together remains the same: to apply their knowledge and skill to the mental health needs of people everywhere.

Key Terms

American Psychological Society (APS) The professional psychological organization formed in 1988 when an academic-scientific contingent broke off from the APA. Goals of the APS include advancing the discipline of psychology, preserving its scientific base, and promoting public understanding of the field and its applications.

behavior therapy A popular or learning framework for treating disorders that is based on the principles

of conditioning. Behavior therapy usually focuses on observable behavior and is typically of relatively brief duration.

behavioral assessment An approach to understanding and changing behavior by identifying the context in which it occurs (the situations or stimuli that either precede it or follow from it).

brief (time-effective) therapy Generally speaking, therapy of 15 or fewer sessions' duration. Brief therapy has gained popularity in recent years due to the financial constraints imposed by managed care, as well as studies demonstrating that its effectiveness is on par with that of traditional psychotherapy.

community psychology A psychological specialty that focuses on the prevention and treatment of mental health problems, particularly among people that are traditionally underserved.

eclectics Clinicians that employ the techniques of more than one theoretical orientation. The nature of the presenting problem determines which orientation to use in a given case.

etiological Causal. For example, an etiological factor for depression is believed to contribute to its onset.

g A term introduced by Charles Spearman to describe his concept of a general factor of intelligence.

guidance clinics Clinics devoted to the evaluation and treatment of children's intellectual and behavioral difficulties.

health psychology A psychological specialty that focuses on the prevention of illness, the promotion and maintenance of good health, and the psychological treatment of individuals with diagnosed medical conditions.

manualized treatment Treatment that is presented and described in a manual format (i.e., outlining the rationales, goals, and techniques that correspond to each phase of the treatment).

measurement of intelligence The use of tests to measure various mental capacities (e.g., the speed of mental processes, the ability to learn over trials).

mental tests The term coined by James McKeen Cattell to describe his measures of individual differences in reaction time. He believed that performance on these tests was associated with intelligence.

neuropsychological assessment An assessment approach—based on empirically established brain–behavior relationships—that evaluates a person's relative strengths and weaknesses across a number of areas (e.g., memory, speed of processing, and manual dexterity).

objective measures Psychological tests that draw conclusions about people's states or traits on the basis of their responses to unambiguous stimuli, such as rating scales or questionnaire items. Responses to objective measures are often interpreted using a nomothetic approach.

personality disorders Enduring and maladaptive patterns of experience and behavior that emerge by adolescence or young adulthood and persist through much of adulthood. Examples include the paranoid, antisocial, and dependent personality disorders.

personality testing The use of measures or techniques to provide insight into enduring characteristics or traits.

play therapy A technique, derived from traditional Freudian principles, that uses expressive play to help release anxiety or hostility. Proponents believe that such a release has a curative effect.

projective techniques Psychological testing techniques, such as the Rorschach or the Thematic Apperception Test, that use people's responses to ambiguous test stimuli to make judgments about their personality traits or their psychological state.

psychoanalysis A framework for understanding and treating mental illness based on the collaborative work of Breuer and Freud in the late 1800s.

psychodiagnosis The use and interpretation of psychological test scores for the purposes of diagnosis and treatment planning.

psychotherapy research Research that evaluates the effectiveness of therapy or certain therapy components. Psychotherapy research may be used to determine which intervention is more effective for treating a certain condition or which component of a particular therapy is most crucial for bringing about an observed change.

radical behaviorism A movement in psychology that began in the late 1950s and persisted through the 1960s. Proponents of this movement asserted that only overt behaviors could be measured and even questioned the existence of personality traits.

scientist-practitioner model The principal model for clinical psychology training of the past 50 years (also referred to as the Boulder model). This model

strives to produce professionals who can effectively integrate the roles of scientist and practitioner.

structured diagnostic interviews A class of assessment tools, all of which consist of questions keyed to diagnostic criteria. The term *structured* means that interviewers ask all interviewees the same questions in the same order and score the answers in standard ways.

systematic desensitization A behavioral technique for the treatment of anxiety disorders in which patients practice relaxation while visualizing anxiety-provoking situations of increasing intensity.

Web Sites of Interest

To visit any of the following Web sites, go to academic.cengage.com/psychology/trull.

2-1 American Psychological Association

2-2 American Psychological Society

2-3 Society for a Science of Clinical Psychology

2-4 Classics in the History of Psychology

2-5 Daily Calendar of Events in the History of Psychology

2-6 Society of Clinical Psychology (Division 12 of the APA)

2-7 Web sites dedicated to specific individuals important in the history of psychology

2-8 Women in Psychology