Chapter 1
Clinical Psychology
Definition and Training

What Is Clinical Psychology?
Original Definition
More Recent Definitions

Education and Training in Clinical Psychology
Balancing Practice and Science: The Scientist-Practitioner (Boulder) Model
Leaning Toward Practice: The Practitioner-Scholar (Vail) Model

Box 1.1. Comparing PhD Programs With PsyD Programs

Leaning Toward Science: The Clinical Scientist Model
Getting In: What Do Graduate Programs Prefer?

Box 1.2. Interview Questions to Anticipate
Internships: Predoc and Postdoc
Getting Licensed

Professional Activities and Employment Settings
Where Do Clinical Psychologists Work?
What Do Clinical Psychologists Do?

How Are Clinical Psychologists Different From . . .
Counseling Psychologists
Psychiatrists
Social Workers
School Psychologists
Professional Counselors
Welcome to clinical psychology! Throughout this book, you’ll learn quite a bit about this field: history and current controversies, interviewing and psychological assessment methods, and psychotherapy approaches. Let’s start by defining it.

**WHAT IS CLINICAL PSYCHOLOGY?**

### Original Definition

The term clinical psychology was first used in print by Lightner Witmer in 1907. Witmer was also the first to operate a psychological clinic (Benjamin, 1996, 2005). More about Witmer’s pioneering contributions will appear in Chapter 2, but for now, let’s consider how he chose to define his emerging field. Witmer envisioned clinical psychology as a discipline with similarities to a variety of other fields, specifically medicine, education, and sociology. A clinical psychologist, therefore, was a person whose work with others involved aspects of treatment, education, and interpersonal issues. At his clinic, the first clients were children with behavioral or educational problems. However, even in his earliest writings, Witmer (1907) foresaw clinical psychology as applicable to people of all ages and with a variety of presenting problems.

### More Recent Definitions

Defining clinical psychology is a greater challenge today than it was in Witmer’s time. The field has witnessed such tremendous growth in a wide variety of directions that most simple, concise definitions fall short of capturing the field in its entirety. As a group, contemporary clinical psychologists do many different things, with many different goals, for many different people.

Some in recent years have tried to offer “quick” definitions of clinical psychology to provide a snapshot of what our field entails. For example, according to various introductory psychology textbooks and dictionaries of psychology, clinical psychology is essentially the branch of psychology that studies, assesses, and treats people with psychological problems or disorders (e.g., Myers, 2013, VandenBos, 2007). Such a definition sounds reasonable enough, but it is not without its shortcomings. It doesn’t portray all that clinical psychologists do, how they do it, or who they do it for.

An accurate, comprehensive, contemporary definition of clinical psychology would need to be more inclusive and descriptive. The Division of Clinical
Psychology (Division 12) of the American Psychological Association (APA) defines clinical psychology as follows:

The field of Clinical Psychology integrates science, theory, and practice to understand, predict, and alleviate maladjustment, disability, and discomfort as well as to promote human adaptation, adjustment, and personal development. Clinical Psychology focuses on the intellectual, emotional, biological, psychological, social, and behavioral aspects of human functioning across the life span, in varying cultures, and at all socioeconomic levels. (APA, 2012a)

The sheer breadth of this definition reflects the rich and varied growth that the field has seen in the century since Witmer originally identified it. (As Norcross and Sayette, 2012, put it, “Perhaps the safest observation about clinical psychology is that both the field and its practitioners continue to outgrow the classic definitions” [p. 1].) Certainly, its authors do not intend to suggest that each clinical psychologist spends equal time on each component of that definition. But, collectively, the work of clinical psychologists does indeed encompass such a wide range. For the purposes of this textbook, a similarly broad but somewhat more succinct definition will suffice: Clinical psychology involves rigorous study and applied practice directed toward understanding and improving the psychological facets of the human experience, including but not limited to issues or problems of behavior, emotions, or intellect.

EDUCATION AND TRAINING IN CLINICAL PSYCHOLOGY

In addition to explicit definitions such as those listed above, we can infer what clinical psychology is by learning how clinical psychologists are educated and trained. The basic components of clinical psychology training are common across programs and are well established (Vaughn, 2006). The aspiring clinical psychologist must obtain a doctoral degree in clinical psychology, about 2,800 of which are awarded each year (Norcross & Sayette, 2012). Most students enter a doctoral program with only a bachelor’s degree, but some enter with a master’s degree. For those entering with a bachelor’s degree, training typically consists of at least 4 years of intensive, full-time coursework, followed by a 1-year, full-time predoctoral internship. Required coursework includes courses on psychotherapy, assessment, statistics, research design and methodology, biological bases of behavior, cognitive-affective bases of behavior, social bases of behavior, individual differences, and other areas. A master’s thesis and doctoral dissertation are also commonly required, as is a
practicum in which students start to accumulate supervised experience doing clinical work. When the on-campus course responsibilities are complete, students move on to the predoctoral internship, in which they take on greater clinical responsibilities and obtain supervised experience on a full-time basis. This predoctoral internship, along with the postdoctoral internship that occurs after the degree is obtained, is described in more detail below.

Beyond these basic requirements, especially in recent decades, there is no single way by which someone becomes a clinical psychologist. Instead, there are many paths to the profession. One indication of these many paths is the multitude of specialty tracks within clinical psychology doctoral programs. Indeed, more than half of APA-accredited doctoral programs in clinical psychology offer (but may not require) training within a specialty track. The most common specialty areas are clinical child, clinical health, forensic, family, and clinical neuropsychology (Perry & Boccaccini, 2009). (Each of these specialty areas receives attention in a later chapter of this book.) Another indication of the many paths to the profession of clinical psychology is the coexistence of three distinct models of training currently used by various graduate programs: the scientist-practitioner (Boulder) model, the practitioner-scholar (Vail) model, and the clinical scientist model. Let's consider each of these in detail.

Balancing Practice and Science: The Scientist-Practitioner (Boulder) Model

In 1949, the first conference on graduate training in clinical psychology was held in Boulder, Colorado. At this conference, training directors from around the country reached an important consensus: Training in clinical psychology should jointly emphasize both practice and research. In other words, to become a clinical psychologist, graduate students would need to receive training and display competence in the application of clinical methods (assessment, psychotherapy, etc.) and the research methods necessary to study and evaluate the field scientifically (Klonoff, 2011). Those at the conference also agreed that coursework should reflect this dual emphasis, with classes in statistics and research methods as well as classes in psychotherapy and assessment. Likewise, expectations for the more independent aspects of graduate training would also reflect the dual emphasis: Graduate students would (under supervision) conduct both clinical work and their own empirical research (thesis and dissertation). These graduate programs would continue to be housed in departments of psychology at universities, and graduates would be awarded the PhD degree. The term **scientist-practitioner model** was used to label this two-pronged approach to training (McFall, 2006; Norcross & Sayette, 2012).
For decades, the scientist-practitioner—or the Boulder model—approach to clinical psychology training unquestionably dominated the field (Klonoff, 2011). In fact, more programs still subscribe to the Boulder model than to any other. However, as time passed, developments took place that produced a wider range of options in clinical psychology training. The pendulum did not remain stationary at its midpoint between practice and research; instead, it swung toward one extreme and then toward the other.

**Leaning Toward Practice: The Practitioner-Scholar (Vail) Model**

In 1973, another conference on clinical psychology training was held in Colorado—this time, in the city of Vail. In the years preceding this conference, some discontent had arisen regarding the Boulder or scientist-practitioner model of training. In effect, many current and aspiring clinical psychologists had been asking, “Why do I need such extensive training as a scientist when my goal is simply to practice?” After all, only a minority of clinical psychologists were entering academia or otherwise conducting research as a primary professional task. Clinical practice was the more popular career choice (Boneau & Cuca, 1974; McConnell, 1984; Stricker, 2011), and many would-be clinical psychologists sought a doctoral-level degree with less extensive training in research and more extensive training in the development of applied clinical skills. So the practitioner-scholar model of training was born, along with a new type of doctoral degree, the PsyD. Since the 1970s, graduate programs offering the PsyD degree have proliferated. In fact, in the 1988 to 2001 time period alone, the number of PsyD degrees awarded increased by more than 160% (McFall, 2006). Compared with PhD programs, these programs typically offer more coursework directly related to practice and fewer related to research and statistics (Norcross et al., 2008). See Box 1.1 for a point-by-point comparison of PhD and PsyD models of training.

The growth of the PsyD (or practitioner-scholar or Vail model) approach to training in clinical psychology has influenced the field tremendously. Of course, before the emergence of the PsyD, the PhD was the only doctoral degree for clinical psychology. But, currently, more than half the doctoral degrees being awarded in the field are PsyD degrees (Norcross, Kohout, & Wicherski, 2005). The number of PsyD programs is actually quite small in comparison with the number of PhD programs—about 80 versus about 250—but the typical PsyD program accepts and graduates a much larger number of students than does the typical PhD program, so the number of people graduating with each degree is about the same (roughly 1,400 each) (Klonoff, 2011; Norcross & Sayette, 2012; Stricker, 2011).
Quite a bit of variation exists between PhD programs, just as it does between PsyD programs. However, a few overall trends distinguish one degree from the other. In general, compared with PhD programs, PsyD programs tend to

- place less emphasis on research-related aspects of training and more emphasis on clinically relevant aspects of training;
- accept and enroll a much larger percentage and number of applicants;
- be housed in free-standing, independent (or university-affiliated) “professional schools,” as opposed to departments of psychology in universities;
- accept students with lower Graduate Record Examination (GRE) scores and undergraduate grade point averages (GPAs);
- offer significantly less funding to enrolled students in the form of graduate assistantships, fellowships, tuition remission, and so on;
- accept and enroll a higher percentage of students who have already earned a master’s degree;
- have lower rates of success placing their students in APA-accredited predoctoral internships;
- produce graduates who score lower on the national licensing exam (EPPP);
- graduate students in a briefer time period (about 1.5 years sooner);
- graduate students who pursue practice-related careers rather than academic or research-related careers; and
- have at least a slightly higher percentage of faculty members who subscribe to psychodynamic approaches, as opposed to cognitive-behavioral approaches.


Table 1.1, which features data from a large-scale survey of graduate programs (Graham & Kim, 2011), offers more detailed findings regarding the general trends listed above.

### Table 1.1 Comparison of PsyD and PhD Programs in Clinical Psychology

<table>
<thead>
<tr>
<th>Variable</th>
<th>PsyD</th>
<th>PhD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean GRE (Verbal + Quantitative) score of admitted students</td>
<td>1116</td>
<td>1256</td>
</tr>
<tr>
<td>Mean undergraduate GPA</td>
<td>3.4</td>
<td>3.6</td>
</tr>
</tbody>
</table>
Leaning Toward Science: The Clinical Scientist Model

After the advent of the balanced Boulder model in the late 1940s and the subsequent emergence of the practice-focused Vail model in the 1970s, the more empirically minded members of the clinical psychology profession began a campaign for a strongly research-oriented model of training.

Indeed, in the 1990s, a movement toward increased empiricism took place among numerous graduate programs and prominent individuals involved in clinical psychology training. In essence, the leaders of this movement argued that science should be the bedrock of clinical psychology. They sought and created a model of training—the clinical scientist model—that stressed the scientific side of clinical psychology more strongly than did the Boulder model (McFall, 2006). Unlike those who created the Vail model in the 1970s, the leaders of the clinical scientist movement have not suggested that graduates of their program should receive an entirely different degree—they still award the PhD, just as Boulder model graduate programs do. However, a PhD from a clinical scientist program implies a very strong emphasis on the scientific method and evidence-based clinical methods.

Two defining events highlight the initial steps of this movement. In 1991, Richard McFall, at the time a professor of psychology at Indiana University, published an article that served as a rallying call for the clinical scientist movement. In this “Manifesto for a Science of Clinical Psychology,” McFall (1991) argued that “scientific clinical psychology is the only legitimate and acceptable form of clinical psychology . . . after

<table>
<thead>
<tr>
<th>Variable</th>
<th>PsyD</th>
<th>PhD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of students receiving at least partial tuition remission or assistantship</td>
<td>13.9</td>
<td>78.4</td>
</tr>
<tr>
<td>Number of students in incoming class</td>
<td>37.4</td>
<td>9.7</td>
</tr>
<tr>
<td>Percentage of applicants attending</td>
<td>26.3</td>
<td>7.4</td>
</tr>
<tr>
<td>Percentage successfully placed in APA-accredited predoctoral internships</td>
<td>66.0</td>
<td>92.8</td>
</tr>
</tbody>
</table>

all, what is the alternative? . . . Does anyone seriously believe that a reliance on intuition and other unscientific methods is going to hasten advances in knowledge?” (pp. 76–77).

A few years later, a conference of prominent leaders of select clinical psychology graduate programs took place at Indiana University. The purpose of the conference was to unite in an effort to promote clinical science. From this conference, the Academy of Psychological Clinical Science was founded. McFall served as its president for the first several years of its existence, and as time has passed, an increasing number of graduate programs have become members. The programs in this academy still represent a minority of all graduate programs in clinical psychology, but among the members are many prominent and influential programs and individuals (Academy of Psychological Clinical Science, 2009).

Considering the discrepancies between the three models of training available today—the traditional, middle-of-the-road Boulder model; the Vail model, emphasizing clinical skills; and the clinical scientist model, emphasizing empiricism—the experience of clinical psychology graduate students varies widely from one program to the next. In fact, it’s no surprise that in the Insider’s Guide to Graduate Programs in Clinical and Counseling Psychology (Norcross & Sayette, 2012), a valuable resource used by many applicants to learn about specific graduate programs in clinical psychology, the first information listed about each program is that program’s self-rating on a 7-point scale from “practice oriented” to “research oriented.” Moreover, it’s no surprise that applicants can find programs at both extremes and everywhere in between. Table 1.2 includes examples of specific graduate programs representing each of the three primary training models (scientist-practitioner, practitioner-scholar, and clinical scientist), including quotes from the programs’ own websites that reflect their approach to training.

Just as training in clinical psychology has changed dramatically throughout its history, it continues to change today and promises to change further in the future (Grus, 2011). Undoubtedly, technology is increasingly influential in the training of clinical psychologists. For an increasing number of students, learning psychotherapy or assessment techniques involves the use of webcams and other computer-based methods that allow supervisors to view, either live or recorded, students trying to apply what they have learned in class (Barnett, 2011; Manring, Greenberg, Gregory, & Gallinger, 2011; Wolf, 2011). Another growing emphasis in training is specific competencies, or skills the students must be able to demonstrate. Emphasizing competencies ensures that the students who graduate from clinical psychology programs not only will have earned good grades on exams, papers, and other academic tasks but also will be able to apply what they have learned. Specific competencies that may be required of students could center on intervention (therapy), assessment, relationship, research, consultation/education, management, and diversity (Barlow & Carl, 2011; Peterson, Peterson, Abrams, Stricker, & Ducheny, 2010).
<table>
<thead>
<tr>
<th>Graduate Program</th>
<th>Training Model</th>
<th>Degree Awarded</th>
<th>Clinical/ Research Rating</th>
<th>Self-Description on Program Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indiana University</td>
<td>Clinical scientist</td>
<td>PhD</td>
<td>7</td>
<td>“Indiana University’s Clinical Training Program is designed with a special mission in mind: To train first-rate clinical scientists. . . . Applicants with primary interests in pursuing careers as service providers are not likely to thrive here.”</td>
</tr>
<tr>
<td>Northwestern University</td>
<td>Clinical scientist</td>
<td>PhD</td>
<td>7</td>
<td>“The Clinical Psychology Program . . . is designed to train students for primary careers in research and teaching in clinical psychology. . . . The major emphasis of the program is clinical research and research methods.”</td>
</tr>
<tr>
<td>University of California, Los Angeles</td>
<td>Clinical scientist</td>
<td>PhD</td>
<td>7</td>
<td>“The curriculum is designed to produce clinical scientists: clinically well-trained psychologists devoted to the continuous development of an empirical knowledge base in clinical psychology, with a particular emphasis on preparing graduates for employment in academic and research settings.”</td>
</tr>
<tr>
<td>Yale University</td>
<td>Clinical scientist</td>
<td>PhD</td>
<td>7</td>
<td>“The Clinical Psychology area is dedicated to research and training in clinical science. Unlike many scientist-practitioner programs, the main training objective at Yale is to cultivate the development of scholars through exposure to a rich and multidisciplinary array of research opportunities. . . . The clinical program at Yale is not a match for students primarily interested in clinical practice.”</td>
</tr>
</tbody>
</table>

(Continued)
<table>
<thead>
<tr>
<th>Graduate Program</th>
<th>Training Model</th>
<th>Degree Awarded</th>
<th>Clinical/Research Rating</th>
<th>Self-Description on Program Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>American University</td>
<td>Boulder/scientist-practitioner</td>
<td>PhD</td>
<td>4</td>
<td>“[Our doctoral program offers] rigorous training in both research and applied clinical work . . . [and] reflects the scientist-practitioner model of training. We provide students with the skills to pursue careers in academics, research, and clinical practice.”</td>
</tr>
<tr>
<td>University of Alabama</td>
<td>Boulder/scientist-practitioner</td>
<td>PhD</td>
<td>4</td>
<td>“Graduates function in a variety of settings as teachers, researchers, and providers of clinical services. . . . The program emphasizes the integration of scientific knowledge and the professional skills and attitudes needed to function as a clinical psychologist in academic, research, or applied settings.”</td>
</tr>
<tr>
<td>Saint Louis University</td>
<td>Boulder/scientist-practitioner</td>
<td>PhD</td>
<td>4</td>
<td>“The mission of the clinical psychology graduate program is to educate and train students broadly in the science and the practice of clinical psychology.”</td>
</tr>
<tr>
<td>DePaul University</td>
<td>Boulder/scientist-practitioner</td>
<td>PhD</td>
<td>4</td>
<td>“The clinical program prepares graduate students to work in applied and academic settings.”</td>
</tr>
<tr>
<td>University of Denver</td>
<td>Vail/practitioner-scholar</td>
<td>PsyD</td>
<td>2</td>
<td>“[Our] mission is to provide an innovative educational environment that promotes the application of psychological theory, knowledge, skills, and attitudes/values to professional practice. . . . The mission of the PsyD program is to train competent doctoral level practitioner/scholars.”</td>
</tr>
<tr>
<td>Chicago School of Professional Psychology</td>
<td>Vail/practitioner-scholar</td>
<td>PsyD</td>
<td>2</td>
<td>“As a professional school, our focus is not strictly on research and theory but on preparing students to become outstanding practitioners, providing direct service to help individuals and organizations thrive.”</td>
</tr>
</tbody>
</table>
**Graduate Program** | **Training Model** | **Degree Awarded** | **Clinical/Research Rating** | **Self-Description on Program Website**
---|---|---|---|---
Alliant University, San Diego | Vail/practitioner-scholar | PsyD | 2 | “[Ours is] a Practitioner-Scholar model program . . . emphasizing the applications of theory and research to clinical practice. The program develops competent professional clinical psychologists . . . who have acquired the skills necessary to deliver a variety of clinical services to people from diverse backgrounds within many types of settings and institutions.”

Argosy University, Washington, D.C. | Vail/practitioner-scholar | PsyD | 1 | “The PsyD in Clinical Psychology degree program at Argosy University’s Washington, D.C., campus emphasizes the development of knowledge, skills, and attitudes essential in the formation of professional psychologists who are committed to the ethical provision of quality services.”


**NOTE:** Clinical/research ratings by directors of each graduate program, as reported in Norcross and Sayette (2012). Ratings range from 1 (“practice oriented”) to 7 (“research oriented”), with 4 representing “equal emphasis.”

**Getting In: What Do Graduate Programs Prefer?**

The *Insider’s Guide* mentioned above (Norcross & Sayette, 2012) is one of several resources to educate and advise aspiring clinical psychology graduate students. Others include *Graduate Study in Psychology* (APA, 2012b) and *Getting In: A Step-by-Step Plan*...
for Gaining Admission to Graduate School in Psychology (APA, 2007). Getting into a graduate program in clinical psychology is no easy task: Admission rates are competitive, and the application process is demanding. (On average, PhD programs in clinical psychology receive 270 applications and admit only 6% of them; Norcross & Sayette, 2012). Knowing how to prepare, especially early in the process, can provide an applicant significant advantages. Among the suggestions offered by resources such as those listed above are the following:

- **Know your professional options.** Numerous roads lead to the clinical psychologist title; moreover, numerous professions overlap with clinical psychology in terms of professional activities. Researching these options will allow for more informed decisions and better matches between applicants and graduate programs.

- **Take, and earn high grades in, the appropriate undergraduate courses.** Graduate programs want trainees whose undergraduate programs maximize their chances of succeeding at the graduate level. Among the most commonly required or recommended courses are statistics, research/experimental methods, psychopathology, biopsychology, and personality (Norcross & Sayette, 2012). Choose electives carefully, too—classes that have direct clinical relevance, including field studies or internships, are often seen favorably (Mayne et al., 1994).

- **Get to know your professors.** Letters of recommendation are among the most important factors in clinical psychology graduate admissions decisions (Norcross, Hanych, & Terranova, 1996). Professors (and, to some extent, supervisors in clinical or research positions) can be ideal writers of such letters—assuming the professor actually knows the student. The better you know the professor, the more substantial your professor’s letter can be. For example, a professor may be able to write a brief, vaguely complimentary letter for a quiet student who earned an A in a large lecture course. But the professor would be able to write a much more meaningful, persuasive, and effective letter for the same student if the two of them had developed a strong working relationship through research, advising, or other professional activities.

- **Get research experience.** Your experience in a research methods class is valuable, but it won’t distinguish you from most other applicants. Conducting research with a professor affords you additional experience with the empirical process, as well as a chance to learn about a specialized body of knowledge and develop a working relationship with the professor (as described above). If your contribution is significant enough, this research experience could also yield a publication or presentation on which you are listed as an author, which will further enhance your application file. In some cases, professors seek assistants for ongoing projects they have designed. In others, the undergraduate student may approach the faculty member with an original
idea for an independent study. Regardless of the arrangement, conducting research at the undergraduate level improves an applicant’s chances of getting into and succeeding in a graduate program.

• Get clinically relevant experience. For undergraduates, the options for direct clinical experience (therapy, counseling, interviewing, testing, etc.) are understandably limited. Even for those who have earned a bachelor’s degree and are considering returning to school at the graduate level, clinical positions may be hard to find. However, quite a few settings may offer exposure to the kinds of clients, professionals, and issues that are central to clinical psychology. These settings include community mental health centers, inpatient psychiatric centers, crisis hotlines, alternative schools, camps for children with behavioral or emotional issues, and others. Whether the clinical experience takes the form of an internship or practicum (for which course credit is earned), a paid job, or a volunteer position, it can provide firsthand knowledge about selected aspects of the field, and it demonstrates to admissions committees that you are serious and well informed about clinical psychology.

• Maximize your GRE score. Along with undergraduate GPA, scores on the GRE are key determinants of admission to graduate programs. Appropriately preparing for this test—by learning what scores your preferred programs seek, studying for the test either informally or through a review course, taking practice exams, and retaking it as necessary—can boost your odds of admission.

• Select graduate programs wisely. Getting in is certainly important, but getting into a program that proves to be a bad match benefits neither the student nor the program. It is best to learn as much as possible about potential programs: What is the model of training (Boulder, Vail, or clinical scientist)? To what clinical orientations does the faculty subscribe? What areas of specialization do the faculty members represent? What clinical opportunities are available? Of course, your own preferences or constraints—geography, finances, family—deserve consideration as well.

• Write effective personal statements. In addition to the many other items in your application file, graduate programs will require you to write a personal statement (or goal statement). This is your opportunity to discuss career aspirations, as well as your research and clinical interests—all of which should fit well with the program to which you are applying. It is also a chance to explain in more detail information that may have appeared only briefly on a resume or vita, such as clinical experiences or research with an undergraduate professor. Make sure your writing ability appears strong and that you don’t make the statement overly personal or revealing.

• Prepare well for admissions interviews. Most doctoral programs invite high-ranking applicants for an in-person interview. These interviews are a wonderful opportunity for professors in the program to get to know you and for you to get to
know the program. Arrive (professionally dressed, of course) with a strong understanding of the program and your interest in it. The more specific, the better: Interest in particular professors’ research concentrations, for example, makes a better impression than the fact that the program has a strong reputation. Box 1.2 lists some of the questions you should be prepared to answer. And don’t forget to develop a list of your own questions—good questions can solicit more detailed information than you were able to find on the program’s website and can impress interviewers in the process.

**Box 1.2 Interview Questions to Anticipate**

There is no formula for the kinds of questions that interviewers might ask an applicant to a clinical psychology program, but these questions are especially common. Whether they ask these particular questions or not, you enhance your chances of finding a graduate program that truly fits your interests by giving them serious consideration.

- Why do you want to be a clinical psychologist?
- What attracts you to our graduate program specifically?
- What are your research interests?
- What approach(es) to psychotherapy do you prefer?
- Which of our faculty members would you like to work with?
- What are your long-term career goals? If you were a student in our program, what would you like to do after you graduated?

**SOURCE:** Adapted from Norcross and Sayette (2012).

- **Consider your long-term goals**. Down the road, do you see yourself as a clinician or a researcher? Have you firmly determined your own theoretical orientation already, or do you seek a program that will expose you to a variety? What specific areas of clinical or scientific work are most interesting to you? How much financial debt are you willing to incur? Thinking ahead about these and other questions can increase the likelihood that you will find yourself at a graduate program at which you thrive and that sets you up for a fulfilling career.

**Internships: Predoc and Postdoc**

All clinical psychology doctoral programs culminate in the predoctoral internship (Kaslow & Webb, 2011). Typically, this internship consists of a full year of supervised clinical experience in an applied setting—a psychiatric hospital, a
Veterans Affairs medical center, a university counseling center, a community mental health center, a medical school, or another agency where clinical psychologists work (Baker & Pickren, 2011). As implied by the term *predoctoral*, this internship year takes place before the PhD or the PsyD is awarded. (Along with completion of the dissertation, it is likely to be one of the final hurdles.) It is generally considered a year of transition, a sort of advanced apprenticeship in which the individual begins to outgrow the role of “student” and grow into the role of “professional.” In some settings, it is also an opportunity to gain more specialized training than may have been available in graduate school so far. Many internships are accredited by the APA; those that are not may be looked on less favorably by state licensing boards.

The process of applying for a predoctoral internship can feel a lot like the process of applying to graduate school some years earlier. It often involves researching various internships, applying to many, traveling for interviews, ranking preferences, anxiously awaiting feedback, and relocating to a new geographic area. Some students apply to 20 or more internship sites (Keilin, 2000), but 10 to 15 may be more reasonable and equally effective (Keilin & Constantine, 2001). Adding stress to the situation is the fact that in some years, the number of graduate students seeking predoctoral internships has either approached or exceeded the number of available slots (Kaslow & Webb, 2011; Keilin, Thorn, Rodolfa, Constantine, & Kaslow, 2000). In fact, the shortage worsened considerably from 2002 to 2012, as the number of students who applied but were not successfully placed at an internship more than doubled (Dingfelder, 2012). The internship application process can certainly generate stress and feel a bit like a game of musical chairs, but numerous strategies to improve the current situation are under way, and applicants are generally successful in finding an internship position—especially if they don’t overly restrict themselves in terms of the number of applications or geographic range.

Beyond the predoctoral internship and the doctoral degree that follows, most states require a *postdoctoral internship* (or postdoc) for licensure as a psychologist. The postdoc typically lasts 1 to 2 years (Vaughn, 2006), and it is essentially a step up from the predoctoral internship. Postdocs take on more responsibilities than they did as predoctoral interns, but they remain under supervision. Like the predoctoral internship, the postdoc often provides an opportunity for specialized training. After postdoctoral interns accumulate the required number of supervised hours (and pass the applicable licensing exams), they can become licensed to practice independently. Some clinical psychologists obtain postdoc positions that are explicitly designed from the start to meet licensing requirements for a particular state; sometimes, such positions are continuations of predoctoral internship experiences. Other clinical psychologists may obtain an entry-level position with an agency and tailor it to meet postdoctoral requirements for licensure.
Getting Licensed

Once all the training requirements are met—graduate coursework, predoctoral internship, postdoctoral internship—licensure appears on the horizon. Becoming licensed gives a professional the right to identify as a member of the profession—to present oneself as a psychologist (or clinical psychologist—the terminology, as well as licensing requirements in general, differs from state to state). It also authorizes the psychologist to practice independently (APA, 2007; Schaffer, DeMers, & Rodolfa, 2011).

But you won’t be handed a license when you get your doctoral degree or when you finish your postdoc. Becoming licensed also requires passing licensure exams—typically, the Examination for Professional Practice in Psychology (EPPP) and a state-specific exam on laws and ethics. The EPPP is a standardized multiple-choice exam on a broad range of psychology topics; all U.S. states and most provinces of Canada establish a minimum score for licensure (Rehm & Lipkins, 2006; Schaffer et al., 2011). The state exams vary, of course, according to state regulations but tend to center on legal issues relevant to the practice of psychology in the state in question. The state exams may be written or oral.

Once licensed, clinical psychologists in many states must accumulate continuing education units (CEUs) to renew the license from year to year (Neimeyer & Taylor, 2011). In various states, psychologists can meet these ongoing requirements in a number of ways—by attending workshops, taking courses, undergoing additional specialized training, passing exams on selected professional reading material, and the like. The purpose of requiring CEUs is to ensure that clinical psychologists stay up to date on developments in the field, with the intention of maintaining or improving the standard of care they can provide to clients.
PROFESSIONAL ACTIVITIES AND EMPLOYMENT SETTINGS

Where Do Clinical Psychologists Work?

The short answer is that clinical psychologists work in a wide variety of settings but that private practice is the most common. In fact, this answer applies not only according to a survey of clinical psychologists conducted in the 2000s but also according to similar surveys in the 1980s and 1990s (Norcross & Karpiak, 2012).

Since the 1980s, private practice has been the primary employment site of 30% to 41% of clinical psychologists. The second-place finisher in each survey during that time has been the university psychology department, but that number has not exceeded 19%. Between 2% and 9% of clinical psychologists have listed each of the following as their primary work setting: psychiatric hospitals, general hospitals, community mental health centers, medical schools, and Veterans Affairs medical centers. Interestingly, the third-place finisher (after private practice and university psychology department) in each survey since the 1980s has been the “other” category; for example, in 2003, 15% of psychologists listed “other,” writing in diverse settings such as government agency, public schools, substance abuse center, corporation, and university counseling center. It is clear that although private practice remains a common destination, clinical psychologists are finding employment across an expanding range of settings (Norcross & Karpiak, 2012; Norcross, Karpiak, & Santoro, 2005).
What Do Clinical Psychologists Do?

Again, the short answer first: Clinical psychologists are engaged in an enormous range of professional activities, but psychotherapy is foremost. As with employment settings, this finding is true today and has been for decades—at least since the 1970s (Norcross & Karpiak, 2012).

Since 1973, the number of clinical psychologists reporting that they are involved in psychotherapy has always outranked that of any other professional activity and has ranged from 76% to 87%. Moreover, when asked what percentage of their time they spend in each activity, clinical psychologists have reported that they spend between 31% and 37% of their time conducting psychotherapy—a percentage more than double that of any other activity. Of those who practice psychotherapy, individual therapy occupies the largest percentage of their therapy time (76%), with group, family, and couples therapy far behind (6% to 9% each) (Norcross & Karpiak, 2012).

Of course, a sizable number of psychologists—more than half—have also reported that they are at least somewhat involved in each of the following activities: diagnosis/assessment, teaching, supervision, research/writing, consultation, and administration. Of these, diagnosis and assessment generally occupy more of clinical psychologists’ time than do the others. Overall, it is evident that “clinical psychologists are involved in multiple professional pursuits across varied employment sites” (Norcross, Karpiak, & Santoro, 2005, p. 1474). In fact, more than half of clinical psychologists hold at least two professional positions (Norcross & Sayette, 2012). Figure 1.1 illustrates the professional self-views of clinical psychologists.

HOW ARE CLINICAL PSYCHOLOGISTS DIFFERENT FROM . . .

Counseling Psychologists

There may have been a time when counseling psychology and clinical psychology were quite distinct, but today, there is significant overlap between these two professions. Historically, they have differed primarily in terms of their clients’ characteristics: Clinical psychologists were more likely to work with seriously disturbed individuals, whereas counseling psychologists were more likely to work with (“counsel”) less pathological clients. But today, many clinical and counseling psychologists see the same types of clients, sometimes as colleagues working side by side. These two fields are also similar in that their graduate students occupy the same internship sites, often earn the same degree (the PhD), and obtain the same licensure status (Norcross, 2000). In fact, the two professions share so much common ground that it is entirely possible for a client who seeks the services of a
A few meaningful differences, however, remain between clinical and counseling psychologists. Compared with counseling psychologists, clinical psychologists still tend to work with more seriously disturbed populations and, correspondingly, tend to work more often in settings such as hospitals and inpatient psychiatric units. And compared with clinical psychologists, counseling psychologists still tend to work with less seriously disturbed populations and, correspondingly, tend to work more often in university counseling centers (Gaddy et al., 1995). Some differences in theoretical orientation are also evident: Both fields endorse the eclectic orientation more than any other, but clinical psychologists tend to endorse behaviorism more strongly, and counseling psychologists tend to endorse humanistic/client-centered approaches more strongly. Additionally, counseling psychologists tend to be more

**FIGURE 1.1 Professional Self-Views of Clinical Psychologists**

interested in vocational testing and career counseling, whereas clinical psychologists tend to be more interested in applications of psychology to medical settings (Norcross & Sayette, 2012).

Psychiatrists

Unlike clinical (or counseling) psychologists, psychiatrists go to medical school and are licensed as physicians. (In fact, their specialized training in psychiatry doesn’t begin until well into their training; the first several years are often identical to that of other types of physicians.) As physicians, they are allowed to prescribe medication. Until recently, psychologists could not prescribe medication, but as described in Chapter 3, psychologists have rallied in recent years to obtain prescription privileges and have earned important victories in a small number of states.

The difference between psychiatrists and clinical psychologists is more than just medication. The two professions fundamentally differ in their understanding of and approach to behavioral or emotional problems. Clinical psychologists are certainly trained to appreciate the biological aspects of their clients’ problems, but psychiatrists’ training emphasizes biology to such an extent that disorders—depression, anxiety disorders, attention-deficit/hyperactivity disorder (ADHD), borderline personality disorder, and so on—are viewed first and foremost as physiological abnormalities of the brain. So, to fix the problem, psychiatrists tend to fix the brain by prescribing medication. This is not to imply that psychiatrists don’t respect “talking cures” such as psychotherapy or counseling, but they favor medication more than they used to (Harris, 2011; Manninen, 2006). For clinical psychologists, the biological aspects of clients’ problems may not be their defining characteristic; nor is pharmacology the first line of defense. Instead, clinical psychologists view clients’ problems as behavioral, cognitive, emotional—still stemming from brain activity, of course, but amenable to change via nonpharmacological methods.

Social Workers

Traditionally, social workers have focused their work on the interaction between an individual and the components of society that may contribute to or alleviate the individual’s problems. They saw many of their clients’ problems as products of social ills—racism, oppressive gender roles, poverty, abuse, and so on. They also helped their clients by connecting them with social services, such as welfare agencies, disability offices, or job-training sites. More than their counterparts in psychology or psychiatry, they were likely to get into the “nitty-gritty” of their clients’ worlds by visiting their homes or workplaces, or by making contacts on their behalf with organizations that might prove beneficial. When they worked
together with psychologists and psychiatrists (e.g., in institutions), they usually focused on issues such as arranging for clients to transition successfully to the community after leaving an inpatient unit by making sure that needs such as housing, employment, and outpatient mental health services were in place.

In more recent years, the social work profession has grown to encompass a wider range of activities, and the similarity of some social workers (especially those conducting therapy) to clinical psychologists has increased (Wittenberg, 1997). The training of social workers, however, remains quite different from the training of clinical psychologists. They typically earn a master’s degree rather than a doctorate, and although their training includes a strong emphasis on supervised fieldwork, it includes very little on research methods, psychological testing, or physiological psychology. Their theories of psychopathology and therapy continue to emphasize social and environmental factors.

**School Psychologists**

As the name implies, school psychologists usually work in schools, but some may work in other settings such as day-care centers or correctional facilities. Their primary function is to enhance the intellectual, emotional, social, and developmental lives of students. They frequently conduct psychological testing (especially intelligence and achievement tests) used to determine diagnoses such as learning disabilities and ADHD. They use or develop programs designed to meet the educational and emotional needs of students. They also consult with adults involved in students’ lives—teachers, school administrators, school staff, parents—and are involved to a limited degree in direct counseling with students.

**Professional Counselors**

Professional counselors earn a master’s (rather than a doctoral) degree and often complete their training within 2 years. They attend graduate programs in counseling or professional counseling, which should not be confused with doctoral programs in counseling psychology. These programs typically have rather high acceptance rates compared with programs in many similar professions. Professional counselors’ work generally involves counseling, with very little emphasis on psychological testing or conducting research. Correspondingly, their training programs include few if any courses on these topics, focusing instead on providing services to clients. Increasingly, professional counselors are among the clinicians who serve wide varieties of clients in community agencies (Norcross & Sayette, 2012), and they often enter private practice as well. They often specialize in such areas as career, school, addiction, couple/family, or college counseling.
CHAPTER SUMMARY

The scope of clinical psychology has expanded greatly since the inception of the field by Lightner Witmer near the turn of the 20th century. Currently, there are multiple paths to the profession, including three distinct approaches to training: the scientist-practitioner (Boulder) approach, with roughly equal emphasis on empiricism and practice; the practitioner-scholar (Vail) approach, with stronger emphasis on practice; and the clinical scientist approach, with stronger emphasis on empiricism. Gaining admission to a training program is a competitive endeavor. Knowledge of the professional training options, successful completion of the appropriate undergraduate courses, research experience, and clinical experience are among the factors that can distinguish an applicant and enhance chances for admission. The final steps of the training process for clinical psychologists are the predoctoral and postdoctoral internships, in which the trainee practices under supervision to transition into the full-fledged professional role. Licensure, which requires a passing grade on the EPPP as well as state-specific requirements, allows clinical psychologists to practice independently. The most common work setting for clinical psychologists is private practice, but university psychology departments and hospitals of various types are also somewhat frequent. The most common professional activity for clinical psychologists is psychotherapy, but they also spend significant amounts of time in assessment, teaching, research, and supervision activities. The professional roles of counseling psychologists, psychiatrists, social workers, and school psychologists each overlap somewhat with that of clinical psychologists, yet clinical psychology has always retained its own unique professional identity.

KEY TERMS AND NAMES

Academy of Psychological Clinical Science
American Psychological Association (APA)
Boulder model
clinical psychology
clinical scientist model
continuing education units (CEUs)
counseling psychologists
Division of Clinical Psychology (Division 12)
Examination for Professional Practice in Psychology (EPPP)
licensure
Lightner Witmer
postdoctoral internship
practitioner-scholar model
predoctoral internship
professional counselors
psychiatrists
PsyD
Richard McFall
school psychologists
scientist-practitioner model
social workers
Vail model
CRITICAL THINKING QUESTIONS

1. Lightner Witmer originally defined clinical psychology as a discipline with similarities to medicine, education, and sociology. In your opinion, to what extent does contemporary clinical psychology remain similar to these fields?

2. Considering the trends in graduate training models observed recently, how popular do you expect the scientist-practitioner, practitioner-scholar, and clinical scientist models of training to be 10 years from now? What about 50 years from now?

3. What specific types of research or clinical experience do you think would be most valuable for an undergraduate who hopes to become a clinical psychologist?

4. In your opinion, to what extent should graduate programs use the GRE as an admission criterion for graduate school in clinical psychology?

5. In your opinion, how much continuing education should licensed clinical psychologists be required to undergo? What forms should this continuing education take (workshops, courses, readings, etc.)?

STUDENT STUDY SITE RESOURCES

Visit the study site at www.sagepub.com/pomerantz3e for these additional learning tools:

- Self-quizzes
- E-flashcards
- Culture Expert Interviews
- Full-text SAGE journal articles
- Additional web resources
- Mock Assessment Data

QR codes at the end of each chapter link to chapter background videos by the author. Visit http://gettag.mobi using your smartphone browser to download the free Microsoft Tag app. Once installed, scan the tags to go directly to these brief videos.
Chapter 2

Evolution of Clinical Psychology

Origins of the Field

Early Pioneers

William Tuke (1732–1822)
Philippe Pinel (1745–1826)
Eli Todd (1762–1832)
Dorothea Dix (1802–1887)

Lightner Witmer and the Creation of Clinical Psychology

Assessment

Diagnostic Issues

Box 2.1. Is It a DSM Disorder? Decisions to Include or Exclude Potential Disorders

Assessment of Intelligence
Assessment of Personality

Psychotherapy

Box 2.2. The Influence of War on Clinical Psychology

Development of the Profession

Box 2.3. Timeline of Key Historical Events in Clinical Psychology

Origins of the Field

Psychology, as we know, has a long, rich history, with roots winding back to some of the great thinkers of prior millennia, such as Socrates, Plato, and Aristotle (Benjamin, 2007; Ehrenwald, 1991). The history of clinical psychology is certainly rich as well,
but it’s also shorter than some might expect. Of course, in recent decades, the clinical specialization has enjoyed great popularity and notoriety among psychology professionals and the general public; in fact, today, when many people hear of a “psychologist,” they immediately think of a “clinical psychologist” practicing psychotherapy or assessment. This assumption regarding psychology is inaccurate until at least the early 1900s. The discipline of clinical psychology simply didn’t exist until around the turn of the 20th century, and it didn’t rise to prominence for decades after that.

**EARLY PIONEERS**

Even before “clinical psychology” per se had been created, numerous influential individuals in various parts of the world were working to make positive changes in the lives of the mentally ill. Collectively, their accomplishments created a climate from which clinical psychology could emerge. Specifically, in the 1700s and 1800s, the mentally ill were generally viewed and treated much more unfavorably than they are today. In many parts of the world, including much of the Western Hemisphere, they were understood to be possessed by evil spirits. Or they were seen as deserving of their symptoms as a consequence of some reprehensible action or characteristic. They were frequently shunned by society and were “treated” in institutions that resembled prisons more than they did hospitals (Reisman, 1991).

During this time, numerous individuals of various professional backgrounds from Europe and North America assumed the challenge of improving the way people with psychological problems were regarded and treated. Through their efforts, the Western world eventually adopted a new, more humane, approach to the mentally ill, foretelling the emergence of clinical psychology as a formal discipline. The accomplishments of several of these pioneers are described below.

**William Tuke (1732–1822)**

In his homeland of England, William Tuke heard about the deplorable conditions in which the mentally ill lived. He visited asylums to get a firsthand look, and he was appalled by what he saw. Tuke devoted much of his life to improving these conditions. He raised funds to open the York Retreat, a residential treatment center where the mentally ill would always be cared for with kindness, dignity, and decency. (The simple act of labeling his facility a “retreat” suggests a fundamentally different approach to the mentally ill compared with the dominant approach at the time.) Patients received good food, frequent exercise, and friendly interactions with staff. The York Retreat became an example of humane treatment, and
soon similar institutions opened throughout Europe and the United States. Long after his death, Tuke’s family members continued to be involved in the York Retreat and the movement to improve treatment of mentally ill individuals (Reisman, 1991).

**Philippe Pinel (1745–1826)**

What William Tuke was to England, Philippe Pinel was to France—a liberator of the mentally ill. Like Tuke, Pinel worked successfully to move mentally ill individuals out of dungeons in Paris, where they were held as inmates rather than treated as patients (Cautin, 2011; Ehrenwald, 1991). He went to great lengths to convince his contemporaries and those with power in France that the mentally ill were not possessed by devils and that they deserved compassion and hope rather than maltreatment and scorn. He created new institutions in which patients were not kept in chains or beaten but, rather, were given healthy food and benevolent treatment. Particularly noteworthy, Pinel advocated for the staff to include in their treatment of each patient a case history, ongoing treatment notes, and an illness classification of some kind—components of care that suggested he was genuinely interested in improving these individuals rather than locking them away (Reisman, 1991). From Pinel’s *Treatise on Insanity* in 1806, we get a sense of his goal of empathy rather than cruelty for the mentally ill: “To rule [the mentally ill] with a rod of iron, as if to shorten the term of an existence considered miserable, is a system of superintendence, more distinguished for its convenience than for its humanity or success” (as quoted in Ehrenwald, 1991, p. 217).

In Europe in the late 18th and early 19th centuries, society’s views toward the mentally ill were undergoing significant change and “the voices of Pinel and Tuke were part of a growing chorus that sang of individual rights and social responsibility” (Reisman, 1991, p. 9).

**Eli Todd (1762–1832)**

Eli Todd made sure that the chorus of voices for humane treatment of the mentally ill was also heard on the other side of the Atlantic Ocean. Todd was a physician in Connecticut in 1800, a time when only three states had hospitals for the mentally ill. The burden for treating the mentally ill typically fell on their families, who often hid their mentally ill relatives out of shame and embarrassment. Todd had learned about Pinel’s efforts in France, and he spread the word among his own medical colleagues in the United States. They supported Todd’s ideals both ideologically and financially, such that Todd was able to raise funds to open *The Retreat* in Hartford, Connecticut, in 1824. Todd ensured that patients at the Retreat were always treated
in a humane and dignified way. He and his staff emphasized patients’ strengths rather than weaknesses, and they allowed patients to have significant input in their own treatment decisions. Similar institutions were soon opened in other U.S. states as leaders elsewhere learned of Todd’s successful treatment of the mentally ill (Reisman, 1991).

Dorothea Dix (1802–1887)

Despite Todd’s efforts, there were simply not enough hospitals in the United States to treat the mentally ill, and as a result, these individuals were too often sent to prisons or jails in an attempt to find any social institution that could house them. In 1841, Dorothea Dix was working as a Sunday school teacher in a jail in Boston, where she saw firsthand that many of the inmates were there as a result of mental illness or retardation rather than crime. Dix devoted the rest of her life to improving the lives and treatment of the mentally ill. Typically, she would travel to a city, collect data on its treatment of the mentally ill, present her data to local community leaders, and persuade them to treat the mentally ill more humanely and adequately. She repeated this pattern again and again, in city after city, with remarkable success. Her efforts resulted in the establishment of more than 30 state institutions for the mentally ill throughout the United States (and even more in Europe and Asia), providing more decent, compassionate treatment for the mentally ill than they might have otherwise received (Reisman, 1991).

Tuke, Pinel, Todd, and Dix did not create clinical psychology. Their efforts do, however, represent a movement prevalent through much of the Western world in the 1700s and 1800s that promoted the fundamental message that people with mental illness deserve respect, understanding, and help rather than contempt, fear, and punishment. As this message gained power and acceptance, it created fertile ground in which someone—Lightner Witmer, most would argue—could plant the seed that would grow into clinical psychology (Cautin, 2011).

LIGHTNER WITMER AND THE CREATION OF CLINICAL PSYCHOLOGY

Lightner Witmer (1867–1956) received his doctorate in psychology in 1892 in Germany under Wilhelm Wundt, who many view as the founder of experimental psychology. He also studied under James McKeen Cattell, another pioneer of experimental psychology (Reisman, 1991). At the time Witmer received his doctorate, psychology was essentially an academic discipline, a field of research. It had almost
none of the applied functions that characterize the field today. In short, in the late 1800s, psychologists didn’t practice psychology, they studied it.

A major historical shift took place 4 years after Witmer received his doctoral degree when, in 1896, he founded the first psychological clinic at the University of Pennsylvania (Routh, 1996). Although it may be difficult to imagine from our contemporary perspective of the field, this was the first time that the science of psychology was systematically and intentionally applied to people’s problems. At the 1896 convention of the American Psychological Association, Witmer (1897) spoke to his colleagues and fellow members about his clinic and encouraged them to open their own—to “throw light upon the problems that confront humanity” (p. 116)—but they were largely unenthusiastic (Reisman, 1991). Decades later, though, clinical settings would certainly proliferate. By 1914, there were about 20 psychological clinics in the United States, most of which were modeled on Witmer’s (Schultz & Schultz, 2011). By 1935, the number had soared to more than 150, and an issue of Witmer’s journal from that year was dedicated to a survey of activities taking place in these clinics, as well as some specific suggestions for the training of clinical psychologists (Brown, 1935).

In his clinic, Witmer and his associates worked with children whose problems arose in school settings and were related to learning or behavior (Benjamin, 2007). They were referred by their schools, parents, physicians, or community authorities (McReynolds, 1997). Witmer (1907) emphasized that clinical psychology could be applied to adults as well as children, or to problems that had nothing to do with school: “Indeed, the clinical method is applicable even to the so-called normal child. . . . Whether the subject be a child or an adult, the examination and treatment may be conducted and their results expressed in the terms of the clinical method” (p. 9).

In addition to establishing his clinic, Witmer also founded the first scholarly journal in the field (called The Psychological Clinic) in 1907 (Benjamin, 2007). Witmer authored the first article, titled “Clinical Psychology,” in the first issue. This article included the first known publication of the term clinical psychology, as well as a definition of the term and an explanation of the need for its existence and growth. The article began with a description of Witmer’s (1907) innovation: “During the last ten years the laboratory of psychology at the University of Pennsylvania has conducted, under my direction, what I have called a ‘psychological clinic’” (p. 1).
We discussed Witmer's original definition of clinical psychology in Chapter 1, but a consideration in this chapter of Witmer's historical significance gives us an opportunity to examine it further. First, it is worth noting that Witmer defined clinical psychology as related to medicine, education, and social work but stated that physicians, teachers, or social workers would not be qualified to practice clinical psychology. Instead, this new field represented a hybrid of these and other influences, requiring a specially trained professional who, of course, would work collaboratively with members of related fields. It is also interesting that Witmer's definition of clinical psychology is basically uninfluenced by Freud, whose ideas appeared throughout many fields at the time, and that psychotherapy, as it would come to be known, was not explicitly discussed at all. Finally, the treatments that Witmer does discuss in his original definition aren’t accompanied by any mention of a plan for empirically evaluating their effectiveness, which is a bit surprising given Witmer's graduate training as an experimental researcher (Routh, 1996; Witmer, 1907).

So by the late 1800s, the work of Tuke, Pinel, Todd, Dix, and others had set the stage for the birth of clinical psychology. Witmer proudly announced its arrival, and although it would thrive in later years, “clinical psychology in the 1890s was a glimmer, a baby just catching its first breath, drawing its life from the new science of psychology” (Reisman, 1991, p. 44).

**ASSESSMENT**

**Diagnostic Issues**

Categorizing mental illness has been an issue central to clinical psychology since Witmer defined the field. Actually, the debate began long before Witmer entered the picture.

With so many mental disorders tossed around as common terminology today, it can be difficult to imagine a time when such labels didn’t exist at all, at least not in any formal sense. In the 1800s in Europe, labeling systems for mental illness began to take shape in a very rudimentary way. Specifically, mental illnesses were often placed in one of two very broad categories: neurosis and psychosis. Neurotic individuals were thought to suffer from some psychiatric symptoms (including what we would now call anxiety and depression) but to maintain an intact grasp on reality. Psychotic individuals, on the other hand, demonstrated a break from reality in the form of hallucinations, delusions, or grossly disorganized thinking (Reisman, 1991).

**Emil Kraepelin** (1855–1926), considered the “father of descriptive psychiatry” (Reisman, 1991, p. 30), offered a different two-category system of mental illness. Kraepelin differentiated exogenous disorders (caused by external factors) from endogenous disorders (caused by internal factors) and suggested that exogenous...
disorders were the far more treatable type. Kraepelin also assigned names to specific examples of disorders in the broad exogenous or endogenous categories. For example, Kraepelin put forth the term dementia praecox to describe one endogenous disorder similar to what is now known as schizophrenia. Later, he also proposed terms such as paranoia, manic depressive psychosis, involutional melancholia, cyclothymic personality, and autistic personality—terms that had not yet been coined (Millon & Simonsen, 2010). Most of Kraepelin’s specific terms have long since been replaced, but by offering such specific terminology, he set a precedent for the creation of diagnostic terms that eventually led to the Diagnostic and Statistical Manual of Mental Disorders (DSM) (Widiger & Mullins-Sweatt, 2008).

In the United States, long before the appearance of the first DSM, the original reason for categorizing mental disorders was to collect statistics on the population. In 1840, the U.S. Census Bureau included a single category—“idiocy/insanity”—for this purpose. In 1880, there were seven such categories, and soon the American Medical Association and the U.S. Army each made preliminary attempts at classifying mental illness (American Psychiatric Association, 2000).

The original DSM was published by the American Psychiatric Association in 1952, representing a more sophisticated attempt to define and organize mental diagnoses. A revision (DSM-II) followed in 1968, but it was not considered to be significantly different from the original. However, the next revision—DSM-III, which arrived in 1980—signified an entirely new way of thinking about mental disorders. Where DSM and DSM-II included somewhat vague descriptions of each disorder, DSM-III provided specific diagnostic criteria—lists indicating exactly what symptoms constitute each disorder. DSM-III also featured a multiaxial system—still a staple of the DSM system—for the first time. The DSM has been revised several more times, with DSM-III-R, DSM-IV, and DSM-IV-TR appearing in 1987, 1994, and 2000, respectively. Each varies from its predecessor to some extent, but the most drastic change occurred with the publication of DSM-III in 1980 (Lilienfeld & Landfield, 2008; Widiger & Mullins-Sweatt, 2008).

Sheer size is certainly among the most notable differences between DSM-II and DSM-III. In fact, each revision of the DSM has included more disorders than the version it replaced, with the jump between DSM-II and DSM-III being the largest. In the time between the original DSM (in 1952) and DSM-IV (in 1994), the number of disorders increased by more than 300% to a total of 568 distinct diagnoses covering an increasing scope of human behavior (Houts, 2002).

What are the reasons for such an increase? On one hand, it is possible that in a relatively brief period of time, psychological science is accurately recognizing disorders that went unrecognized (or at least unlabeled) for centuries before, an explanation called “scientific discovery.” On the other hand, it is also possible that
psychology is making disorders out of some aspects of human experience that had previously been considered normal, an explanation called “social invention” (Houts, 2002). Ongoing debates have arisen regarding the relative truth of both of these explanations. Debates also continue regarding the expanding range of the DSM, in general, and the inclusion and exclusion of some specific disorders as well. Some of these debates call into question the extent to which factors other than empirical data drive the decision making of DSM authors, and the histories of certain disorders—some of which appear in the DSM, and some of which do not—have been offered as evidence (Caplan, 1995; Eriksen, 2005; Kutchins & Kirk, 1997). Box 2.1 illustrates some of the decisions represented in DSM revisions. Regardless of the outcomes or current status of diagnostic debates, recent DSM revisions represent important chapters of a long history of diagnostic labeling that characterizes clinical psychology.

**Box 2.1 Is It a DSM Disorder? Decisions to Include or Exclude Potential Disorders**

Before each edition of the DSM is published, its authors oversee an extensive process during which they must, among other important tasks, decide whether or not to include certain experiences or sets of symptoms as official diagnoses. The implications of these classification decisions are quite significant for many people, including clients who may be assigned the diagnosis, mental health professionals who may treat them, health insurance companies who may pay for the treatment, and researchers who may investigate the issue.

Sometimes, DSM authors have decided to add an entirely new disorder to a revised edition. For example, borderline personality disorder, narcissistic personality disorder, and social phobia each appeared for the first time in DSM-III in 1980. At other times, DSM authors have, after serious consideration, decided not to include a proposed set of symptoms as an official disorder. For years prior to the publication of DSM-IV, DSM authors contemplated adding disorders tentatively named sadistic personality disorder and self-defeating personality disorder, among others, but ultimately decided against it. On occasion, the DSM authors reverse a previous decision to include a disorder. Homosexuality was listed as a disorder in DSM-I and DSM-II but was excluded from DSM-III (and subsequent editions) after extensive controversy. DSM-III also omitted inadequate personality disorder and asthenic personality disorder, which were included in previous editions.

An appendix of the current edition of the DSM (DSM-IV-TR) lists numerous proposed disorders that were considered for inclusion but rejected by DSM authors. They are included as

*(Continued)*
unofficial “criteria sets” with the hope that additional research will inform future decisions to include or exclude them as official disorders. Included among these proposed disorders are the following:

- **Premenstrual dysphoric disorder**, which includes symptoms such as depression, anxiety, lability, and irritability causing marked interference with work, school, social relationships, and so on
- **Minor depressive disorder**, which requires fewer symptoms than major depressive disorder (two rather than five of the nine that define a depressive episode) but the same duration (2 weeks)
- **Recurrent brief depressive disorder**, which requires the same symptoms as major depressive disorder but for briefer (2-day) periods that recur (once a month for a year)
- **Binge eating disorder**, which is similar to bulimia nervosa in terms of excessive, out-of-control eating but lacks compensatory weight-loss behaviors such as self-induced vomiting, fasting, or excessive exercise (Striegel-Moore & Franko, 2008)

There is no doubt that many individuals experience the phenomena described in these “criteria sets.” The question is whether these experiences should be categorized as forms of mental illness or understood to be part of the range of normal human experience. Whether these experiences will be classified as official disorders in a future edition of *DSM* depends, ultimately, on a decision made by the *DSM* authors.

### Assessment of Intelligence

The emergence of the field of clinical psychology around the turn of the 20th century coincided with a dispute among psychology’s pioneers about the nature of intelligence. **Edward Lee Thorndike** was among those who promoted the idea that each person possesses separate, independent intelligences, whereas **Charles Spearman** led a group of theorists who argued for the existence of “g,” a general intelligence thought to overlap with many particular abilities (Reisman, 1991). The outcome of this dispute would profoundly influence how clinical psychologists
assessed intellectual abilities, an activity that, more than psychotherapy or any other, characterized clinical psychology as a profession in the early years of the profession (Benjamin, 2007).

An important development in the history of intelligence testing arose in the early 1900s, when the French government sought help in determining which public school students should qualify for special services. In response to this request, Alfred Binet (along with Theodore Simon) created the first Binet-Simon scale in 1905. This test yielded a single overall score, endorsing the concept of “g.” It was the first to incorporate a comparison of mental age to chronological age as a measure of intelligence. This comparison, when expressed as a division problem, yielded the “intelligence quotient,” or IQ. Binet’s test grew in popularity and was eventually revised by Lewis Terman in 1916. Terman’s revision was called the Stanford-Binet Intelligence Scales, the name by which the test is currently known (Goldstein, 2008; Reisman, 1991).

The standardization sample and the age range of test takers improved with each new version of Binet’s test, but even after Terman revised it in 1937, it was still a child-focused measure of IQ. In 1939, David Wechsler filled the need for a test of intelligence designed specifically for adults with the publication of his Wechsler-Bellevue test. It quickly became popular among psychologists working with adults, and its more recent revisions remain popular today. Since its creation, Wechsler’s adult intelligence scale has been revised and restandardized numerous times: the Wechsler Adult Intelligence Scale (WAIS) in 1955, the WAIS-R in 1981, and the WAIS-III in 1997 (Goldstein, 2008; Reisman, 1991).

In 1949, Wechsler released a children’s version of his intelligence test (a more direct competitor for the Stanford-Binet), which he called the Wechsler Intelligence Scale for Children (WISC). The WISC distinguished itself from the Stanford-Binet by the inclusion of specific subtests as well as verbal and performance scales (in addition to overall IQ). The WISC has been revised and restandardized several times: the WISC-R in 1974, the WISC-III in 1991, and the WISC-IV in 2003. In 1967, Wechsler added an intelligence test designed for very young children called the Wechsler Preschool and Primary Scale of Intelligence (WPPSI). The WPPSI was revised in 1989 (WPPSI-R) and again in 2002 (WPPSI-III).

Many other measures of child and adult intelligence have appeared during the time of the Stanford-Binet and the Wechsler tests, but more than any others, these two have established themselves as standards in the field. They have also established themselves as competitors in the marketplace of psychological assessment, and recent revisions in one have at times represented responses to successful strides made by the other.

Assessment of Personality

The term mental test was first used by James McKeen Cattell in 1890 in an article titled “Mental Tests and Measurements.” At that time, the term was used to refer to
basic tests of abilities such as reaction time, memory, and sensation/perception. Soon, though, the term encompassed a wider range of measures, including not only the intelligence tests described above but also tests of personality characteristics (Butcher, 2010).

The first two decades of the 20th century witnessed some of the earliest attempts to measure personality attributes empirically, but few had significant impact. In 1921, however, Hermann Rorschach published a test that had significant impact for many years to come. Rorschach, a Swiss psychiatrist, released his now-famous set of 10 inkblots, which rose quickly in popularity (despite the fact that in the early years, several different competing Rorschach scoring systems existed). As a projective personality test, the Rorschach Inkblot Method was based on the assumption that people will “project” their personalities onto ambiguous or vague stimuli; hence, the way individuals perceive and make sense of the blots corresponds to the way they perceive and make sense of the world around them. Psychodynamic practitioners, who dominated during the early and mid-1900s, found such tests especially compatible with their clinical approach to clients.

The success of Rorschach’s test was followed by a number of other projective techniques (Reisman, 1991). For example, Christiana Morgan and Henry Murray published the Thematic Apperception Test (TAT) in 1935. The TAT was similar to the Rorschach in that the test taker responded to cards featuring ambiguous stimuli. However, instead of inkblots, the TAT cards depicted people in scenes or situations that could be interpreted in a wide variety of ways. Instead of identifying objects in the card (as they might with Rorschach’s inkblots), clients were asked to tell stories to go along with the interpersonal situations presented in the TAT cards. Again, their responses were thought to reflect personality characteristics. Other projective techniques that appeared in the aftermath of the Rorschach included the Draw-a-Person test, in which psychologists infer personality characteristics from clients’ drawings of human figures, and Julian Rotter’s Incomplete Sentence Blank (Rotter & Rafferty, 1950), in which psychologists assess personality by examining the ways clients finish sentence stems. Like the Rorschach, these and other projective personality tests have certainly enjoyed some degree of popularity, but their popularity has declined in recent decades as questions about their reliability and validity have accumulated.

Objective personality tests appeared soon after projectives, offering a very different (and, in many cases, more scientifically sound) method of assessing personality. Typically, these tests were pencil-and-paper instruments for which clients answered multiple-choice or true–false questions about themselves, their experiences, or their preferences. Scoring and interpretation were typically more straightforward than for projective tests. Some objective tests focused on specific aspects of personality, whereas others aimed to provide a more comprehensive overview of an individual’s personality. The Minnesota Multiphasic Personality Inventory (MMPI),
written by Starke Hathaway and J. C. McKinley, is perhaps the best example of a comprehensive personality measure. When it was originally published in 1943, it consisted of 550 true–false statements. Test takers’ patterns of responses were compared with those of groups in the standardization sample who represented many diagnostic categories. Not only could this test help a psychologist categorize a client through use of its clinical scales, it also used validity scales to assess the test taker’s approach to the test. In other words, the MMPI had a built-in system to detect random responding or intentionally misleading responses. The MMPI became very popular, and by 1959, there were more than 200 separate scales consisting of combinations of MMPI items (Reisman, 1991).

In 1989, the Minnesota Multiphasic Personality Inventory-2 (MMPI-2) was released. Its norms were more appropriate than those of the original MMPI, especially in terms of including minorities and individuals from various regions of the country in the standardization sample. It also eliminated some of the outdated or confusing language from the original test. An adolescent version of the test (the Minnesota Multiphasic Personality Inventory-Adolescent [MMPI-A]) followed in 1992. All versions of the MMPI have featured hallmarks of high-quality objective personality tests: easy administration and scoring, demonstrable reliability and validity, and clinical utility.

Other objective tests have come and gone but none with the lasting impact or research base of the MMPI. The NEO Personality Inventory (NEO-PI), for example, and its successor, the NEO-PI-R, have risen to some degree of prominence in more recent decades as a personality measure less geared toward psychopathology than is the MMPI (Costa & McCrae, 1985, 1992). Rather than diagnostic categories, its scales are based on universal personality characteristics common to all individuals. Instruments measuring more specific states or traits have also appeared, including the Beck Depression Inventory (now in its second edition) and the Beck Anxiety Inventory (Beck & Steer, 1993; Beck, Steer, & Brown, 1996).

In recent decades, personality assessment tools have been used for an increasingly wider range of purposes, including job screenings and forensic purposes (e.g., child custody evaluations; Butcher, 2010). These uses have often generated significant controversy and highlight the importance of validity and reliability in such tests—topics we cover in more detail in Chapter 6.

**PSYCHOTHERAPY**

Psychotherapy is the primary activity of clinical psychologists today, but that hasn’t always been the case. In fact, in 1930—more than a quarter century after Witmer founded the field—almost every clinical psychologist worked in academia (rather
than as a therapist), and it wasn’t until the 1940s or 1950s that psychotherapy played a significant role in the history of clinical psychology (Benjamin, 2005; Humphreys, 1996; McFall, 2006; Wertheimer, 2000). In fact, in the first half of the 1900s, psychological testing was familiar territory for clinical psychologists, “but it was important that they knew their place in a field dominated by medical practitioners . . . a strategy for treatment, and treatment—those were in the job description of the physician, not the psychologist” (Benjamin, 2007, p. 163). Without the demand created by psychological consequences of World War II on U.S. soldiers, psychotherapy might have remained an uncommon activity of clinical psychologists even longer (Benjamin, 2007). (See Box 2.2 for further exploration of the impact of war on the history of clinical psychology.)

**Box 2.2 The Influence of War on Clinical Psychology**

It is difficult to overestimate the influence of war and its aftermath on the development of clinical psychology as a profession. Therapy, assessment, and training have all been shaped by the attempts of various governments and individuals to select soldiers and treat them after they have served their countries (Baker & Pickren, 2011; Benjamin, 2007; Tryon, 2008). Numerous critical incidents in the history of clinical psychology can be directly tied to military factors:

- Robert Yerkes chaired the Committee on the Psychological Examination of Recruits that created the Army Alpha and Beta intelligence tests during World War I. These tests, which were used to measure the intelligence of recruits and soldiers, are considered precursors to today’s most widely used measures of intelligence (McGuire, 1994).
- David Wechsler’s creation of the Wechsler-Bellevue, his first intelligence test, stemmed from his clinical experiences during World War II. The Influence of War on Clinical Psychology

**Photo 2.3** War has influenced the field of clinical psychology in numerous ways. For soldiers involved in direct combat, how might clinical psychologists be most helpful?
In the middle of the 20th century, when psychotherapy rose to a more prominent place in clinical psychology, the psychodynamic approach to therapy dominated (Routh, 1996). With time, challengers to the psychodynamic approach emerged...
In the 1950s and 1960s, for example, behaviorism surfaced as a fundamentally different approach to human beings and their behavioral or emotional problems. The behavioral approach emphasizes an empirical method, with problems and progress measured in observable, quantifiable terms. This emphasis was in part a reaction to the lack of empiricism evident in psychodynamic psychotherapy. Humanistic (or “client-centered”) therapy also flourished in the 1960s, as Carl Rogers’s relationship- and growth-oriented approach to therapy offered an alternative to both psychodynamic and behavioral approaches that many therapists and clients found attractive. The family therapy revolution took root in the 1950s, and as the 1960s and 1970s arrived, understanding mentally ill individuals as symptomatic of a flawed system had become a legitimate—and, by some clinicians, the preferred—therapeutic perspective.

Most recently, interest in cognitive therapy, with its emphasis on logical thinking as the foundation of psychological wellness, has intensified to the point that it has become the most popular singular orientation among clinical psychologists (excluding eclectic or integrative approaches) (Engel, 2008; Norcross & Karpiak, 2012; O’Donohue, 2009). Apart from the rise of cognitive therapy, the most striking feature of the current therapy marketplace is the utter range of therapy approaches. To illustrate, modern graduate textbooks for psychotherapy courses typically include at least a dozen chapters on distinct approaches (e.g., Corey, 2009; Prochaska & Norcross, 2010), with each chapter representing a full spectrum of more specific variations.

In addition to the sequential rise of these therapy approaches, recent decades have witnessed a movement toward combining them, in either eclectic or integrative ways (Goldfried, Glass, & Arnkoff, 2011), as well as the tremendous influence of cultural competence on any and all such approaches (Comas-Diaz, 2011).

Many of these therapy approaches are covered in detail elsewhere in this book, but for now, the important point is that the plethora of therapy options currently available to clinical psychologists did not always exist. Rather, these methods have evolved over the history of the discipline, with each new therapy approach emerging from the context of—and often as a reaction against—the therapies that came before it.

DEVELOPMENT OF THE PROFESSION

Just as clinical psychology’s primary activities, such as psychotherapy and assessment, have evolved, the profession itself has progressed since its inception. Even in the earliest years, significant steps were evident. For example, in 1917, the American Association of Clinical Psychologists was founded, and in 1919 it transitioned into Clinical Section of the American Psychological Association. In 1921,
the Psychological Corporation was founded, foreshadowing the big business that was to become of psychological tests and measures of intelligence and personality.

In the 1940s, education and training in clinical psychology became more widespread and more standardized. The number of training sites increased dramatically, and the American Psychological Association began accrediting graduate programs that offered appropriate training experiences in therapy, assessment, and research. Veterans Affairs hospitals began their long-standing relationship with clinical psychology by funding graduate training and internships. And in 1949, the historic Boulder conference took place, at which training directors from around the country agreed that both practice and research were essential facets of PhD clinical psychology training (Cautin, 2011).

The 1950s produced more evidence that clinical psychology was a burgeoning profession. Therapy approaches proliferated, with new behavioral and humanistic/existential approaches rivaling established psychodynamic techniques. The extent to which psychotherapy did or didn’t work also received increased attention, kick-started by Eysenck’s (1952) critical analysis. The American Psychological Association also published the first edition of its ethical code in 1953, with significant discussion of clinical activities, reflecting a new level of professional establishment for clinical psychology (McFall, 2006; Tryon, 2008).

In the 1960s and 1970s, the profession of clinical psychology continued to diversify, successfully recruiting more females and minorities into the field. Clinical approaches continued to diversify as well, as behaviorism, humanism, and dozens of other approaches garnered large followings. The first PsyD programs appeared, offering graduate training options that emphasized applied clinical skills over research expertise. And signifying that psychotherapy was becoming a recognized part of American health care, insurance companies began to authorize payment for clinical psychologists’ services just as they did for the services of many medical specialists.

In the 1980s, clinical psychologists enjoyed increased respect from the medical establishment as they gained hospital admitting privileges and Medicare payment privileges. Larger numbers of graduate training institutions continued to train larger numbers of new clinical psychologists, and the number of American Psychological Association members who were clinicians approached 50%. Psychotherapy burgeoned, especially in private practice settings, but intelligence and personality testing decreased (Reisman, 1991). The growth of the profession continued through the 1990s and 2000s, as did the trend toward diversity in gender and ethnicity of those joining it (DeLeon, Kenkel, Garcia-Shelton, & Vandenbos, 2011).

The size and scope of the field continues to grow, largely to meet the demand for psychotherapy services. In the late 1950s, only 14% of the U.S. population had ever received any kind of psychological treatment; by 2010, that number had climbed
to 50%. Professional training options continue to multiply as well. Today’s aspiring clinical psychologists have more choices than ever: the science/clinical balance of traditional PhD programs, PsyD programs emphasizing clinical skills, and more selected PhD programs that endorse the clinical scientist model of training and lean heavily toward the empirical side of the science/clinical continuum (Klonoff, 2011; McFall, 1991; Stricker, 2011). Numerous specializations, including forensic psychology and health psychology (illustrated by the inclusion of increasing numbers of clinical psychologists on primary health care teams), are flourishing (Goodheart & Rozensky, 2011). Empirical support of clinical techniques, prescription privileges, and new technologies (as described in Chapter 3) are among the other major professional developments in recent years.

To summarize the events described in this chapter, Box 2.3 presents a timeline of important events in the history of clinical psychology, coded to indicate their relevance to the origins of the field, diagnosis, assessment of intelligence, assessment of personality, psychotherapy, or the development of the profession.

---

**Box 2.3**

**Timeline of Key Historical Events in Clinical Psychology**

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1796</td>
<td>William Tuke opens York Retreat in England</td>
</tr>
<tr>
<td>1801</td>
<td>Philippe Pinel publishes book on humane treatment of mentally ill (<em>Medico-Philosophical Treatise on Mental Alienation or Mania</em>)</td>
</tr>
<tr>
<td>1824</td>
<td>Eli Todd opens The Retreat in Hartford, Connecticut</td>
</tr>
<tr>
<td>1840</td>
<td>U.S. Census Bureau lists one category of mental disorder (“idiocy/insanity”)</td>
</tr>
<tr>
<td>1841</td>
<td>Dorothea Dix encounters mentally ill in Boston prison, prompting extensive efforts for better treatment</td>
</tr>
<tr>
<td>1880</td>
<td>U.S. Census Bureau lists seven categories of mental disorders</td>
</tr>
<tr>
<td>1890</td>
<td>“Mental test” is used in print for the first time by Cattell</td>
</tr>
<tr>
<td>1892</td>
<td>Lightner Witmer earns his doctoral degree</td>
</tr>
<tr>
<td>1893</td>
<td>Emil Kraepelin proposes the early diagnostic category “dementia praecox”</td>
</tr>
<tr>
<td>1896</td>
<td>Lightner Witmer opens the first psychological clinic at the University of Pennsylvania</td>
</tr>
<tr>
<td>Year</td>
<td>Event</td>
</tr>
<tr>
<td>-----------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>1905</td>
<td>Binet-Simon intelligence test is published in France</td>
</tr>
<tr>
<td>1907</td>
<td>Lightner Witmer founds the first professional journal of clinical psychology, <em>The Psychological Clinic</em></td>
</tr>
<tr>
<td>1914</td>
<td>Psychology clinics proliferate; about 20 in operation</td>
</tr>
<tr>
<td>1916</td>
<td>Stanford-Binet Intelligence Test (as translated by Terman) is published in the United States</td>
</tr>
<tr>
<td>1917</td>
<td>American Association of Clinical Psychologists is founded</td>
</tr>
<tr>
<td>1921</td>
<td>Psychological Corporation is founded</td>
</tr>
<tr>
<td>1921</td>
<td>Rorschach inkblot technique published</td>
</tr>
<tr>
<td>1930s to</td>
<td>Psychoanalysis dominates psychotherapy</td>
</tr>
<tr>
<td>1950s</td>
<td></td>
</tr>
<tr>
<td>1935</td>
<td>Thematic Apperception Test published</td>
</tr>
<tr>
<td>1935</td>
<td>Psychology clinics proliferate further; more than 150 in operation</td>
</tr>
<tr>
<td>1939</td>
<td>Wechsler-Bellevue Intelligence Test published; first designed for adults</td>
</tr>
<tr>
<td>1943</td>
<td>Minnesota Multiphasic Personality Inventory (MMPI) published</td>
</tr>
<tr>
<td>1949</td>
<td>Wechsler Intelligence Test for Children (WISC) published</td>
</tr>
<tr>
<td>1949</td>
<td>Boulder conference held; yields scientist-practitioner training model</td>
</tr>
<tr>
<td>1950s to</td>
<td>Alternatives to psychoanalytic psychotherapy emerge (e.g., behaviorism, humanism, family/systems)</td>
</tr>
<tr>
<td>1970s</td>
<td></td>
</tr>
<tr>
<td>1952</td>
<td>Hans Eysenck publishes early, critical review of psychotherapy outcome</td>
</tr>
<tr>
<td>1952</td>
<td><em>Diagnostic and Statistical Manual of Mental Disorders (DSM)</em> published</td>
</tr>
<tr>
<td>1953</td>
<td>American Psychological Association publishes first ethical code</td>
</tr>
<tr>
<td>1955</td>
<td>Wechsler Adult Intelligence Scale (WAIS) published</td>
</tr>
</tbody>
</table>

(Continued)
<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1967</td>
<td>Wechsler Preschool and Primary Scale of Intelligence (WPPSI) published</td>
</tr>
<tr>
<td>1968</td>
<td><em>DSM-II</em> published</td>
</tr>
<tr>
<td>1973</td>
<td>Vail conference held; yields PsyD and practitioner-scholar training model</td>
</tr>
<tr>
<td>1974</td>
<td>WISC-R published</td>
</tr>
<tr>
<td>1974</td>
<td>Cognitive psychotherapy rises in prominence</td>
</tr>
<tr>
<td>1980</td>
<td><em>DSM-III</em> published; specific diagnostic criteria and multiple axes appear</td>
</tr>
<tr>
<td>1981</td>
<td>WAIS-R published</td>
</tr>
<tr>
<td>1985</td>
<td>NEO Personality Inventory (NEO-PI) published</td>
</tr>
<tr>
<td>1987</td>
<td><em>DSM-III-R</em> published</td>
</tr>
<tr>
<td>1989</td>
<td>MMPI-2 published</td>
</tr>
<tr>
<td>1989</td>
<td>WPPSI-R published</td>
</tr>
<tr>
<td>1991</td>
<td>Richard McFall publishes &quot;manifesto&quot;; yields &quot;clinical scientist&quot; training model</td>
</tr>
<tr>
<td>1991</td>
<td>WISC-III published</td>
</tr>
<tr>
<td>1992</td>
<td>MMPI-A published</td>
</tr>
<tr>
<td>1994</td>
<td><em>DSM-IV</em> published</td>
</tr>
<tr>
<td>1997</td>
<td>WAIS-III published</td>
</tr>
<tr>
<td>1999</td>
<td>NEO-PI-R published</td>
</tr>
<tr>
<td>2000</td>
<td><em>DSM-IV-R</em> published</td>
</tr>
<tr>
<td>2002</td>
<td>WPPSI-III published</td>
</tr>
<tr>
<td>2003</td>
<td>WISC-IV published</td>
</tr>
<tr>
<td>2008</td>
<td>WAIS-IV published</td>
</tr>
<tr>
<td>2008</td>
<td>MMPI-2-RF published</td>
</tr>
</tbody>
</table>
CHAPTER 2  Evolution of Clinical Psychology

CHAPTER SUMMARY

The roots of clinical psychology can be traced to pioneering efforts in the late 1700s and 1800s by William Tuke, Philippe Pinel, Eli Todd, Dorothea Dix, and others to treat the mentally ill in a humane rather than punitive way. The field of clinical psychology was formally founded by Lightner Witmer, who founded the first psychological clinic at the University of Pennsylvania in 1896 and created the first professional journal devoted to clinical psychology in 1907. Early efforts to diagnose mental problems were quite rudimentary, but the work of Emil Kraepelin and others eventually led to more sophisticated diagnostic classification systems, culminating in the current edition of the DSM, which defines hundreds of disorders according to specific diagnostic criteria. The assessment of intelligence has evolved from the earliest work of Alfred Binet, David Wechsler, and others to the current editions of their tests, such as the Stanford-Binet and the WAIS, WISC, and WPPSI. Early attempts to assess personality were primarily projective tests, such as the Rorschach inkblot method and the TAT. Those tests were soon followed by objective personality tests such as the MMPI, many of which have achieved high levels of reliability and validity. Although psychotherapy is currently the dominant professional activity of clinical psychologists, it was relatively uncommon until the 1940s and 1950s. At that time, the psychodynamic approach to therapy prevailed, but behaviorism and humanism rose to popularity in the decades that followed. Currently, the cognitive approach is the most popular single-school therapy approach, and the number of distinct approaches to therapy continues to proliferate. As a profession, clinical psychology continues to evolve in many ways, including a diversification of its members and its graduate training options.

KEY TERMS AND NAMES

Alfred Binet  dementia praecox  Emil Kraepelin
behavioral  Diagnostic and Statistical  endogenous disorders
Boulder conference  Manual of Mental Disorders  exogenous disorders
Charles Spearman  diagnostic criteria  family therapy
Christiana Morgan  Dorothea Dix  Henry Murray
cognitive  Edward Lee Thorndike  Hermann Rorschach
David Wechsler  Eli Todd  humanistic
CRITICAL THINKING QUESTIONS

1. How essential were the contributions of William Tuke, Philippe Pinel, Eli Todd, and Dorothea Dix to the creation of the field of clinical psychology? Would the field exist today without their work?

2. Psychotherapy was not even mentioned in Lightner Witmer’s original definition of clinical psychology, but in recent decades, psychotherapy has been the most common activity of clinical psychologists. In your opinion, what factors might have contributed to the rise in prominence of psychotherapy?

3. In your opinion, why has the number of disorders defined by successive editions of the DSM continued to increase?

4. In your opinion, which of the current proposed disorders (e.g., premenstrual dysphoric disorder, minor depressive disorder, recurrent brief depressive disorder, binge eating disorder, as listed in Box 2.1) should be included as official disorders in the next edition of the DSM? On what do you base your opinion?

5. To what extent would you expect a graduate program’s model of training (e.g., scientist-practitioner, practitioner-scholar, or clinical scientist) to influence the types of personality assessment tools (e.g., projective or objective) it trains its students to use?
STUDENT STUDY SITE RESOURCES

Visit the study site at www.sagepub.com/pomerantz3e for these additional learning tools:

- Self-quizzes
- E-flashcards
- Culture Expert Interviews
- Full-text SAGE journal articles
- Additional web resources
- Mock Assessment Data

The author provides additional background and reinforcement of the topics covered in this chapter.