Introduction to CLINICAL PSYCHOLOGY

Third Edition

Michael T. Nietzel / Douglas A. Bernstein
Richard Milich

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To my son, Aaron Engle Nietzel
MTN
To my sister, Ann Harris
DAB

PREFACE

In the first two editions of this book, we tried to accomplish three goals. First, we wanted a book that, while appropriate for graduate students, was written especially with sophisticated undergraduates in mind. Many undergraduate psychology majors express an interest in clinical psychology without having a clear understanding of what the field involves and requires. An even larger number of nonmajors also wish to know more about clinical psychology. We felt that both groups of undergraduates would benefit from a thorough survey of the field which does not go into all the details typically found in "graduate students only" texts.

Second, we wanted to present a scholarly portrayal of the history of clinical psychology, its scope, functions, and future that stressed the value of different theoretical perspectives. For this reason, we did not limit ourselves to our own preferences for cognitive-behavioral theory but instead described three theoretical systems—psychoanalytic, behavioral, and phenomenological—in as neutral a manner as possible. We do champion the empirical research tradition of clinical psychology throughout the book because we believe it is a necessary and useful perspective for all clinicians to follow, regardless of their theoretical orientation.

Third, we wanted to write a book that would be interesting and enjoyable to read. Because we like being clinical psychologists and because we enjoy teaching students about the field, we tried to create a book that would pass that enthusiasm on to others.

In this third edition, our goals are the same, but we have made some changes that we believe strengthen the book. We have streamlined the writing to make the text even more accessible to undergraduates, but we have also retained coverage which is sufficiently comprehensive to make it useful to graduate students. We have updated all the

chapters and rearranged several in order to capture many developments that have occurred in clinical psychology in the last half of the1980s. New material has been added on diagnostic advances (DSM-III-R), research strategies (meta-analysis), innovative treatments (cognitive and interpersonal therapies), specialized assessment instruments (including the latest versions of the MMPI, Stanford-Binet, and other classic tests), and developing professional issues (new perspectives on training and alternative systems for financing mental health care). Finally, we have added an entirely new chapter on clinical child psychology which has proven to be one of the areas of greatest expansion in clinical psychology.

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We want to thank several people for their valuable contributions to this book. Our colleagues, Doug Snyder, David Berry, Art Nonneman, Ruth Baer, Charles Carlson, Steven Landau, Monica Harris, and Tom Widiger carefully read parts of the manuscript and offered many valuable suggestions for its improvement. Paloma Iberra provided excellent library research and tireless commitment to completing the references and indexes. Diane Weidner skillfully coordinated our process of revision. Countless undergraduate and graduate students asked the questions, raised the controversies, and argued opposing positions that have found their way into the text; they are really the people who stimulated this book. Now, we hope they read it. We would also like to express our appreciation to the staff at Prentice Hall, especially Susan Finnemore, Psychology Editor, and Susan Rowan, Production Editor, for their expertise and help in seeing this text to publication. We also owe deep thanks to Shirley Jacobs who once again was single-handedly responsible for producing the manuscript, a task that required skill, patience, and perseverance, all of which she showed in amounts that were simply amazing.

Michael T. Nietzel
Douglas A. Bernstein
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CHAPTER

1

CLINICAL PSYCHOLOGY: DEFINITIONS AND HISTORY

For many years psychology has been one of the most popular majors for undergraduate students in the United States; among the arts and science fields, psychology often ranks first in the number of majors (Astin, Hemond, & Richardson, 1982). At many American universities, more Ph.D.'s are awarded in psychology than in any other discipline. Throughout the 1980s, between 3300 and 3500 doctoral degrees in psychology were granted each year (Howard et al., 1986), with the largest group of them (about 40 percent) earned by students studying clinical psychology (Stapp, Fulcher, & Wicherski, 1984).

During the 1960s and 1970s, one indicator of the popularity of clinical psychology was the claim that it was easier to be admitted to medical school than to be accepted into a doctoral program in clinical psychology. The odds for admission are better now for several reasons. First, an increase in the number of programs offering training in clinical psychology has come at the same time as a decline in the number of college-age persons in the population. Second, the career aspirations of young adults have shifted, with undergraduates increasingly drawn to business and technological careers. This trend is associated with dramatic changes in the demographic characteristics of clinical psychologists. While women received about 15 percent of the doctoral degrees in psychology in 1950, in the 1980s they received more than 50 percent and represent more than half of the full-time graduate students in psychology (Howard et al., 1986; Pion, Bramblett, Wicherski, & Stapp, 1985).

The appeal of clinical psychology is also reflected in the membership of the American Psychological Association (APA), the largest organization of psychologists in the United States. APA has more than 90,000 members, associates and affiliates. Almost half of the members of APA list clinical psy-

chology as their major field (Howard et al., 1986). Of the 47 recognized divisions within APA, the Division of Clinical Psychology is the largest.

The immense popularity of clinical psychology is remarkable considering that it is less than 100 years old and did not begin to grow rapidly until after World War II. What is it that a clinical psychologist does that makes so many people want to become one? To put it more generally, what is clinical psychology? The answer to this question is not simple, but in this book we attempt to describe the field in a way that will allow you to draw your own conclusions. In the process, we shall look at the history, current status, and future of the field; its uniqueness and its overlap with other fields; the training and activities of its members; the factors that unite it and the issues that threaten to divide it.

SOME ATTEMPTS AT DEFINITION

We would like to provide a commonly accepted and easily remembered definition of clinical psychology from which the rest of the material in this book would logically flow. However, no such definition exists. For many years the field has been expanding in so many different directions that any attempt to capture it in a sentence or two is bound to be too vague, too narrow, or soon outdated. This lack of definition has caused confusion in the public's mind over what clinical psychology is all about. The same problem exists to a certain extent among clinical psychologists themselves, who find that the ever-expanding boundaries of the field threaten to make traditional notions of clinical psychology obsolete (Levy, 1984). In spite of continual changes within the field, there is a set of factors underlying most definitions of clinical psychology which provides a workable definition of the discipline.

First, clinical psychology is a specialty within the larger discipline of psychology. Clinical psychologists, like all psychologists, are concerned with the study and understanding of *behavior.* Unlike some psychologists, however, clinicians are concerned almost entirely with *human behavior;* they study animals mainly when the use of human subjects is impractical or unsafe and when the behavior of animals can illuminate general behavioral principles and relationships that are relevant at the human level.

Second, clinical psychologists do *research* on human behavior. Clinical psychology also applies the knowledge and principles gained from research in a practical way, but this alone does not make the field unique; other specialties, such as industrial and educational psychology, are also noted for their applied orientation.

A third aspect of clinical psychology is *assessment or measurement* of the abilities and characteristics of individual human beings. The clinician collects information that will be analyzed and used to support conclusions about the person observed. While such information might be collected from large groups as part of a clinical research project, it is more frequently employed by the clinician to understand the particular individual at hand. However, many nonclinicians (e.g., personality researchers and industrial psychologists) administer and score tests of various kinds. Assessment activities alone cannot fully define clinical psychology or account for its distinctiveness.

A fourth characteristic of clinical psychology is that clinicians *help* people who are psychologically distressed. Therapeutic work is the most recently evolved aspect of the field, but it rivals assessment activities in the general public's image of the clinical psychologist. Nevertheless, providing therapy is not unique to clinical psychology: Psychiatrists, family physicians, social workers, counselors, nurses, educators and the clergy also intervene to alleviate psychological problems.

Where does all this leave us? Clinical psychology is a subarea of psychology. It applies psychological knowledge (as do other sub-

areas); and its members generate research about human behavior, engage in individual assessment, and provide various forms of psychological assistance. However, the defining characteristic that distinguishes clinical psychology from the other branches of psychology is what has been called the *clinical attitude* or the *clinical approach* (Korchin, 1976). This term means that clinical psychologists combine knowledge generated by clinical and other research with their own efforts at individual assessment in order to understand and help a particular person.

The clinical attitude sets clinicians apart from other psychologists whose interests, though often related to clinical psychology, tend to be more abstract because they involve a search for principles and relationships that apply to human behavior problems on a general, or *nomothetic,* level. Clinical psychologists are interested in research of this kind, but they are more concerned with how general principles shape lives, problems, and treatments on an individual, or *idiographic,* level.

The clinical attitude is distinctive with respect to the helping professions outside psychology as well. Psychiatrists, social workers, and others assist people in psychological distress, but their fields are not traditionally noted for research into or systematic assessment of the problems they seek to alleviate. Their involvement with a given case is more likely to focus on treatment.

The clinical attitude and the ways it contrasts with related approaches are most obvious with respect to a given case. For example, in reading a description of the problems of a person just admitted to a mental institution, the psychopathologist would search for psychological or biological relationships that might explain the "disorder," while the psychiatrist (a physician who specializes in psychological problems) might weigh the potential benefits of psychological, medical, or combined treatment. The clinical psychologist, however, would plan a strategy for further assessment of the problem and, depending upon the outcome of the assessment process, develop an intervention for reducing the person's distress. The research evidence that guides the clinical psychologist in these pursuits (and also aids other helping professions) often comes from the work of fellow clinical psychologists.

So it is not the research, the individual assessment, the treatment, or any of the other activities that makes clinical psychology unique. Rather, it is the clinical attitude, the idea of not only learning about behavior (particularly problematic behavior) but also doing something about it that is indigenous to clinical psychology (Wyatt, 1968, p. 235). This emphasis is consistent with APA's official definition of a clinical psychologist as a professional who applies principles and procedures to understand, predict, and alleviate intellectual, emotional, psychological, and behavior problems (APA, 1981). It is this combination *within a single discipline* of research, assessment, and intervention, aimed at understanding human behavior and distress on an individual basis, that provides the substance of clinical psychology.

CLINICAL PSYCHOLOGISTS AT WORK

Now that we have outlined the nature of clinical psychology, we will survey the range of things that clinical psychologists do, the variety of places in which they are employed, and the array of clients and problems with which they work. Our examples of clinical activities, work settings, clients, and problems are only a small sample; it is possible to describe others. On the other hand, our coverage is so broad that it is unlikely any given clinical psychologist will be associated with all the functions, locations, clients, and problems listed.

We look first at some isolated examples of clinical activities, settings, clients, and problems. Later we shall see how these dimensions are combined for individual clinicians.

The Activities of Clinical Psychologists

The popular stereotypes of the clinician as mind reader, hypnotist, psychotherapist, or mental tester are, like most stereotypes, only partly accurate at best. Empirical research by clinical psychologists is a vital though underpublicized aspect of the field. In addition, clinicians often engage in teaching, consultation, and administration. It is probably fair to say that 95 percent of all clinical psychologists spend their working lives engaged in some combination of six activities: *assessment, treatment, research, teaching, consultation,* and *administration.*

Assessment. Assessment involves the collection of information about people: their behavior, problems, unique characteristics, abilities, and intellectual functioning. This information may be used to diagnose problematic behavior, to guide a client toward an optimal vocational choice, to facilitate selection of job candidates, to describe a client's personality characteristics, to select treatment techniques, to aid legal decisions regarding the commitment of individuals to institutions, to provide a more complete picture of a client's problems, to screen potential participants in a psychological research project, to establish pretreatment baseline levels of behavior against which to measure posttreatment improvement, and for literally hundreds of other purposes. Most clinical assessment devices fall into one of three categories: *tests, interviews,* and *observations.*

Tests, interviews, and observations are not always distinct means of assessment. For example, a clinician may observe the nonverbal behavior of a client during a testing session or an interview to estimate the client's level of discomfort in social situations. Further, a test may be embedded in an interview, as when the client is asked to provide specific information whose accuracy provides clues to reality contact.

Various modes of assessment are combined in assessment *batteries* and *multiple assessment* strategies. Here, information necessary for the clinician's work is collected through a series of procedures sometimes including a variety of tests; often, a more elaborate combination of tests, interviews, and observations is used to focus not only on the client, but also on significant others who can provide additional information.

Treatment. This function of the clinical psychologist involves helping people better understand and solve distressing psychological problems. The intervention may be called psychotherapy, behavior modification, psychological counseling, or other names, depending upon the orientation of the clinician, and may involve many combinations of clients and therapists. Though psychotherapy is the single most frequent activity of clinicians today (Norcross, Prochaska, & Gallagher, 1989a), it is also common for one psychologist to deal with groups of clients (e.g., family members, co-workers, hospital residents). Sometimes two or more clinicians work as a team to deal with the problems of an individual, couple, or group. The emphasis of treatment may be on alleviating the distress and/or problematic behavior of one or more troubled individuals, or may include prevention of psychological problems by altering the institutions, social or environmental situation, or behavioral skills of persons "at risk" (e.g., teenage parents) or of an entire community, Herink (1980) lists more than 250 different "brand names" of therapy ranging literally from A (Aikido) to Z (Zaraleya psychoenergetic technique).

Treatment by a clinical psychologist may be on an outpatient basis (the client lives in the community) or may be part of the services for residents (inpatients) of an institution. It may be as brief as one session or extend over several years. Treatment sessions may consist of anything from client or therapist monologues to painstaking construction of new behavioral skills to episodes of intense emotional drama, and may range from highly structured to totally spontaneous interactions. The goals of clinician and client may be limited (as when a solution to a specific prob-

lem is sought), ambitious (as when a complete analysis and reconstruction of the client's personality is planned), or may fall somewhere between these extremes. Therapy may be conducted free of charge, on a sliding scale based on client income, or in return for very large fees. In given cases, treatment can result in anything from worsening of client problems to no change to vast improvement.

Research. By training and by tradition, clinical psychologists are research-oriented. This research activity makes them notable among other helping professions; some assert that it is in this area that clinicians make their greatest contribution (see Box 1-1). In the realm of psychotherapy, for example, theory and practice were once based mainly upon case study evidence, subjective impressions of treatment efficacy, and rather poorly designed research. This "prescientific" era (Paul, 1969a) in the history of psychotherapy research has now evolved into an "experimental" era in which the quality of research has improved greatly and the conclusions we can draw about the effects of therapy are much stronger (Smith, Glass & Miller, 1980). This development is due in large measure to the research of clinical psychologists.

In recent years there has been some shift away from the research emphasis in the training of clinicians. This change is due in part to an erosion of the number of academic-research jobs available and in part to students' greater interests in careers that emphasize clinical service. We discuss this issue more extensively in Chapter 13, but for now we want to point out that clinical psychology will risk its special identity as a mental health profession if it neglects research training in favor of purely professional objectives.

The areas investigated by clinicians include neuropsychology, behavioral medicine, stress and social support, social problems, childhood problems, community development, psychopharmacology, developmental problems, geriatrics, test construction and validation, personality diagnosis and adjustment, psychoanalytic theory, therapeutic processes, brain damage and mental retardation, behavior disorders, marriage and family problems, outcomes of various forms of psychological treatment, the design and analysis of experiments, and the value and training of nonprofessionals as therapeutic agents. A journal called *Psychological Abstracts* contains brief summaries of clinical and other psychological research; a glance at a few issues will document the diversity and intensity of the clinician's involvement in research. Another journal, *Clinical Psychology Review,* first published in 1981, includes longer reviews of topics germane to clinical psychology. The *Journal of Consulting and Clinical Psychology* and the *Journal of Abnormal Psychology* publish many of the most influential research studies conducted by clinical psychologists (Feingold, 1989).

Clinical investigations vary greatly with respect to their setting and scope. Some are conducted in the controlled confines of a laboratory, while others are run in the more natural but often uncontrollable circumstances of the real world. Some projects are carried out by clinicians who are aided by paid research assistants and clerical personnel and supported by funds from governmental or private sources, but a great deal of research is performed by clinicians whose budgets are limited and who depend on volunteer help and their own ability to scrounge for space, equipment, and subjects.

Teaching. A considerable portion of many clinical psychologists' time is spent in educational activities. Clinicians who hold full- or part-time academic positions conduct graduate and undergraduate courses in such areas as personality, abnormal psychology, introductory clinical psychology, psychotherapy, behavior modification, interviewing, psychological testing, research design, and clinical assessment.

Clinicians often conduct specialized graduate seminars on advanced topics; frequently they supervise the work of graduate students who are learning assessment and

BOX 1-1 The clinician and research

One issue that may confuse students who are considering clinical psychology as a career is why so much emphasis is placed on research methods and skills. Graduate school admission committees may give more weight to students' performance in a statistics course than to how they have done in abnormal psychology, and show more interest in their research activities than in their clinical experiences (Purdy, Reinehr, & Swartz, 1989). Most students who are fortunate enough to be invited to interview at graduate programs in clinical psychology know that it is important that they present a balance of research and clinical interests, even if they ultimately plan to go into private practice.

This emphasis on research methodology differentiates clinical psychology programs from other mental health professions. For example, medical students are not required to undertake their own research projects, and they may obtain only brief exposure to issues in experimental methods.

The research emphasis in clinical psychology does not reflect a desire to steer all graduates toward an academically oriented career. As noted earlier, only about 20% of clinical psychologists wind up in academic positions, and the market could not support increased numbers even if the desire were there. It is also not assumed that most graduates of clinical programs will combine research and clinical work in their professional lives. In fact, surveys of clinical psychologists consistently indicate that approximately 25 percent never publish any research (Barrom, Shadish, & Montgomery, 1988). This is in contrast to Ph.D.'s in biology, where less than 5 percent have no publications (Schuckman, 1987).

Given that the majority of graduates of clinical psychology programs pursue clinically oriented careers, why do training programs place strong emphasis on research training? We can list at least three reasons. First, an attempt is made to produce clinicians who can critically evaluate the published research to determine what assessment procedures and therapeutic interventions are most effective for clients. A therapist who relies upon summaries of published studies is likely either to apply effective therapies to the wrong clients, or to rely upon interventions that are ineffective.

A second purpose is to give clinicians the means to evaluate the effectiveness of their own clinical work. This goal is accomplished by intensively exposing students to factors that influence therapeutic outcomes, as well as offering training in objective means of evaluating effectiveness.

Finally, many psychologists who work in medical or community mental health centers find that they are the ones to whom other professionals turn when research is needed, whether to write a grant proposal or undertake assessments of program effectiveness. In fact, a survey by Barrom et al. (1988) found that over half of the clinical psychologists reported currently being engaged in some form of research activity. Thus, whether they intend to pursue research activities, the majority of clinical psychologists can assume that their research skills will be called upon sometime in their professional careers.

therapy skills in practicum courses. Supervision of a practicum is a special kind of teaching that combines the use of research evidence and other didactic material with the clinician's own experience to guide students' assessment and treatment of actual clients. Practicum teaching usually involves a model in which the student sees a client on a regular basis and, between these sessions, also meets with the supervisor (the client is aware of the

"I can tell you one thing right off—you can't solve your problems by running away."

FIGURE 1-1 Drawing by Richter; © 1947, 1975, The New Yorker Magazine, Inc.

student's status and of the participation of the supervisor). Supervision may occur on an individual basis or may be part of a meeting with a small group of practicum students, all of whom maintain the confidentiality of any material discussed.

The clinician's teaching task is particularly delicate in practica since a balance must be struck between directing the student and allowing sufficient independence. The therapist-in-training may feel stifled if supervision is too heavy-handed. At the same time, the supervisor is ultimately responsible for the case and cannot allow the student to make serious errors that would be detrimental to client welfare.

A good deal of teaching by clinical psychologists involves supervising undergraduate and graduate students' research efforts. This kind of teaching begins when a student comes to the supervisor with a research topic and asks for advice and a list of relevant readings. In addition to providing the reading list, most research supervisors help the student frame appropriate research questions, apply basic principles of research design in answering those questions, and introduce the student to research skills relevant to the problem at hand. These tasks require considerable skill if the supervisor is to avoid giving the student so much guidance and direction that the student simply becomes an assistant who, instead of wrestling with and learning from research problems, merely carries out orders.

Much teaching by clinical psychologists involves in-service (i.e., on-the-job) training of psychological, medical, or other interns, as well as social workers, nurses, institutional aides, ministers, police officers, suicide pre-

vention and other hotline personnel, prison guards, teachers, administrators, business executives, day-care workers, lawyers, probation officers, dentists, and many other groups whose vocational skills might be enhanced by increased psychological sophistication. Some clinical psychologists also teach in the context of therapy (particularly those who adopt a behavioral approach to treatment; see Chapter 9) since part of therapy involves helping people learn more adaptive ways of behaving.

One last point about clinical psychologists as teachers: They are often not formally trained for the job. The same might be said, of course, about other psychologists (and many other Ph.D.'s, for that matter), but the lack of attention to teaching in clinical training programs is unfortunate because educational activities are such an integral part of clinicians' work. This significant omission is due in part to the fact that clinical training time is so precious that most of it is taken up with research, assessment, and treatment functions.

Consultation. Clinical psychologists often provide advice to organizations about a variety of problems. This activity is called consultation; it combines research, assessment, treatment, and teaching. Perhaps this is why some clinicians find consultation satisfying and lucrative enough that they engage in it full time. Organizations that benefit from consultants' expertise range in size and scope from one-person medical or law practices to huge government agencies and multinational corporations. The consultant may also work with neighborhood associations, walk-in treatment centers, and many other community-based organizations.

Rather than cataloging all the consulting activities in which a clinical psychologist might engage, we will review basic dimensions of the consulting function. The first of these is the *orientation* or *goal* of the consultation. When consulting is *case*-oriented, the clinician focuses attention on a case and either deals with it directly or offers advice as to how it might be handled. An example would be providing treatment for a problem case in a mental health agency or medical facility. When consultation is *program-* or *administration*-oriented, it focuses not on case-level problems but on those aspects of organizational function or structure that are causing trouble. For example, the consultant may develop new procedures for screening candidates for various jobs within an organization, set up criteria for identifying promotable personnel, or reduce staff turnover rates by increasing administrators' awareness of the psychological impact of their decisions on employees.

A second dimension of consultation is *locus of responsibility.* In some cases, responsibility for the solution to an organization's problem is transferred to the consultant, as when a mental health clinic contracts for the assessment of suspected cases of brain damage among new clients. In such instances, responsibility for the cases rests with the clinician; giving advice and then going home is not appropriate. More commonly, however, the responsibility for problem resolution remains with the organization served. A clinician may participate in decisions about which treatment would be of greatest benefit to a client, but if the client gets worse instead of better, the consultant is not held culpable. The ultimate responsibility remains with the clinic.

A third major consulting dimension involves *functions.* A partial account of what a consultant could do for an organization might include education (e.g., familiarizing staff with relevant reading materials), advice (e.g., about cases or programs), direct service (e.g., assessment, treatment, and evaluation), and reduction of intraorganizational conflict (e.g., eliminating sources of trouble by altering personnel assignments).

Successful consultation is not easy. The clinician must be aware of his or her role as an outsider and of the implications of that role. The consultant's presence might be resented and resisted by rank-and-file personnel if they see it as a threat to their jobs. Inter-