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WHAT IS CLINICAL PSYCHOLOGY?

Chapter Preview

In this chapter we introduce the field of clinical psychology. We first outline the requirements for becoming a clinical psychologist and discuss the profession's popularity. Next we describe how clinical psychology relates to other mental health professions. We describe the work activities of most clinical psychologists and the rewards of the profession, financial and otherwise. Finally, we introduce some of the key issues shaping the field today. These issues include how to (a) strike a balance between science and practice, (b) train new clinicians, (c) combine divergent theoretical approaches, and (d) adapt clinical practice to a changing health care environment.

A Clinical Case

Bonnie, a 15-year-old European American girl in 9th grade, asked her parents to get her some help to deal with her fear and anxiety. They did so, and as part of the intake evaluation at her first appointment, Bonnie was interviewed by a clinical psychologist specializing in treatment of childhood anxiety disorders. At the beginning of the interview, Bonnie said her problem was that she would “get nervous about everything,” particularly about things at school and doing anything new. When asked to give an example, Bonnie mentioned that her father wanted her to go to camp during the coming summer, but she did not want to go to camp because of her “nerves.” It soon became clear that Bonnie’s anxiety stemmed from a persistent fear of social situations in which she might be the focus of other people’s attention. She said she felt very self-conscious in the local mall and constantly worried about what others might be thinking of her. She was also fearful of eating in public, using public restrooms, being in crowded places, and meeting new people. She almost always tried to avoid such situations. She experienced anxiety when talking to her teachers and was even more afraid of talking to store clerks and other unfamiliar adults. Bonnie would not even answer the telephone in her own home.

In most of these situations, Bonnie said that her fear and avoidance related to worry about possibly saying the wrong thing or not knowing what to say or do, which would lead others to think badly of her. Quite often, her fear in these situations became so intense that she experienced a full-blown panic attack, complete with rapid heart rate, chest pain, shortness of breath, hot flashes, sweating, trembling, dizziness, and difficulty swallowing.

To get a clearer picture of the nature of Bonnie’s difficulties, the psychologist conducted a separate interview with Bonnie’s parents. While confirming what their daughter had said, they reported that Bonnie’s social anxiety was even more severe than she had described it. (Based on Brown & Barlow, 2001, pp. 37–38.)

How can we best understand Bonnie’s fears and anxieties? How did her problems develop, and what can be done to help her overcome them? These questions are important to Bonnie, her loved ones, and anyone interested in her condition, but the questions are especially important to clinical psychologists.

In this book you will learn how clinical psychologists address problems such as those faced by Bonnie. You will learn how clinicians assess and treat persons with psychological problems, how they conduct research into the causes and treatments for psychological disorders, and how they are trained. You will learn how clinical psychologists have become key providers of health care in the United States and in other countries, and how clinical psychology continues to evolve and adapt to the social, political, and cultural climate in which it is practiced.

AN OVERVIEW OF CLINICAL PSYCHOLOGY

SECTION PREVIEW

Here we define clinical psychology and identify the essential requirements satisfied by its practitioners. We also discuss the continued appeal of clinical psychology, popular conceptions of clinical psychologists, and how clinical psychology overlaps with, and differs from, other mental health professions.

As its name implies, clinical psychology is a subfield of the larger discipline of psychology. Like all psychologists, clinical psychologists are interested in *behavior and mental processes*. Like some other psychologists, clinical psychologists generate research about human behavior, seek to apply the results of that research, and engage in individual assessment. Like the members of some other professions, clinical psychologists provide assistance to those who need help with psychological problems. It is difficult to capture in a sentence or two the ever-expanding scope and shifting directions of clinical psychology. Nevertheless, we can outline the central features of the discipline as well as its many variations.

Definition of Clinical Psychology

The definition of clinical psychology adopted by the American Psychological Association's Division of Clinical Psychology reads as follows: "The field of Clinical Psychology integrates science, theory, and practice to understand, predict, and alleviate maladjustment, disability, and discomfort as well to promote human adaptation, adjustment, and personal development. Clinical Psychology focuses on the intellectual, emotional, biological, social, and behavioral aspects of human functioning across the life span, in varying cultures, and at all socioeconomic levels" (American Psychological Association, Division 12, 2012). As you can see, the definition focuses on the *integration* of science and practice, the *application* of this integrated knowledge across diverse human populations, and the *purpose* of alleviating human suffering and promoting health. But what are the requirements to become a clinical psychologist?

Personal Requirements to Be a Clinical Psychologist

Certain requirements for those wishing to be clinical psychologists have more to do with attitudes and character than with training and credentialing. Perhaps the most notable distinguishing feature of clinical psychologists has been called the *clinical attitude* or the *clinical approach* (Korchin, 1976), which is the tendency to combine knowledge from research on human behavior and mental processes with efforts at individual assessment in order to understand and help a particular



Clinical psychology's purpose is to alleviate human suffering and promote health. Those wishing to become clinical psychologists must satisfy rigorous personal, legal, and educational requirements. *Source:* Alina Solovyova-Vincent/E+/Getty Images.

person. The clinical attitude sets clinicians apart from other psychologists who search for general principles that apply to human behavior problems in general. Clinical psychologists are interested in research of this kind, but they also want to know how general principles shape lives, problems, and treatments on an individual level.

Because clinical psychology is both rigorously scientific and deeply personal, it requires that people entering the field have a strong and compassionate interest in human beings. Clinical training programs' admissions committees look for a number of characteristics as they make decisions about which applicants to admit to graduate study in clinical psychology. Personality variables such as an interest in people, integrity in dealing with others, emotional stability, and intellectual curiosity are of particular importance in selecting candidates (Johnson & Campbell, 2004; Prideaux et al., 2011; Swaminathan, 2012). These traits are important in many jobs, but they are crucial in clinical psychology because clinicians regularly work in situations that can have significant and lasting personal and interpersonal consequences. Even those clinical researchers who don't themselves offer psychotherapy may still make decisions about matters of personal consequence to participants, so integrity, emotional stability, and sound judgment are required for them, too.

The potential impact that clinical psychologists can have helps explain why, when considering candidates for admission to graduate training in clinical psychology, many psychology departments tend to rank letters of recommendations, personal statements, and interviews as slightly more important than more standardized academic indicators such as grade point averages or Graduate Record Exam (GRE) scores (Norcross, Kohout, & Wicherski, 2005). Nevertheless, as noted in Chapter 16, "Getting into Graduate School in Clinical Psychology," those standardized academic admission requirements for clinical psychology programs are typically quite high and predictive of success on the national licensing examination required to practice as a clinical psychologist (Sharpless & Barber, 2013).

Legal, Educational, and Ethical Requirements to Be a Clinical Psychologist

As one of psychology's *health service provider* subfields, clinical psychology requires its practitioners to receive specific training. In addition to having a degree from an accredited institution, those who practice clinical psychology must be licensed or certified to do so by state and national agencies. In the United States and Canada, each state or province establishes the requirements for licensure in clinical psychology, awards licenses to those who qualify, and retains the power to penalize or revoke the licenses of those who violate licensing laws. In other words, clinical psychology, like medicine, pharmacy, law, and dentistry, is a legally regulated profession.

Legal requirements vary not only by state but also by levels of training. For instance, in most states a *full license* in clinical psychology allows one to practice independently, to "hang out a shingle." Fully licensed clinicians can rent or own their own offices, set fees, establish work hours, bill insurance companies or other third parties, consult, testify in court, and engage in a number of other activities characteristic of independent private practice. These privileges usually come after a trainee has completed a doctoral-level degree that includes course work, research training, and the additional requirements listed below.

EDUCATION How much additional education beyond the bachelor's is required? An earned doctorate from an accredited program is the basic educational requirement for clinical psychology licensure (American Psychological Association, Division 12, 2012). Students complete substantial advanced coursework in psychopathology, assessment, and intervention strategies, and they become involved in conducting clinical research. Most states also require continuing education training for the periodic renewal of licenses.

Doctoral-level degrees for fully licensed clinical psychologists are typically either the *PhD* or the *PsyD*, though they occasionally include others (e.g., the *EdD*, or Doctor of Education). The *PhD* and *PsyD* degrees both stress intensive clinical training in preparation for clinical practice, but they differ in the extent to which science and research are stressed. Later in this chapter and in subsequent chapters, we explain the differences in these two models of training and describe the debates about the advantages and disadvantages of each. For now, just be aware that the number of doctoral-level psychologists produced by the two models has shifted; *PsyD* programs now accept and graduate more doctoral-level clinical psychologists than *PhD* programs do (Sayette, Norcross, & Dimoff, 2011).

At the subdoctoral level, practitioners have titles such as *limited license psychologist*, *marriage and family therapist*, *psychological assistant*, *mental health counselor*, and similar terms. To obtain a limited license, one usually needs a master's degree and a specific period of postgraduate supervised experience. Some states regulate the limited license much as they regulate the doctoral-level license, but other states provide less oversight, or no oversight, for subdoctoral practitioners (Sales, Miller, & Hall, 2005). Many states place limits on the practice of clinicians who are not fully licensed. An example would be requiring that the subdoctoral-level clinician always practices under the supervision of a fully licensed psychologist. Unfortunately, subdoctoral degrees are too often accompanied by restricted or lesser levels of reimbursement from insurance companies, lower salaries, and higher job turnover (Rajecki & Borden, 2011). This is not to say that qualified master's-level clinicians provide inferior services—well-trained masters level clinicians have helped millions of people—but rather, as in medicine, law, or any other profession, higher levels of training are usually associated with higher levels of skill in those areas and greater financial rewards. Given that clinical psychology is such a popular and competitive field, the best advice for students contemplating entry into this field is to resolve to work very hard and to seek the highest levels of training available.

EXPERIENCE Some term of supervised practice in the field, often embodied in successful completion of an approved practicum, internship, or period of supervision is also a critical part of a clinical psychologist's required training. The duration of supervised practice varies, but one-year and two-year internships are common. Students are typically paid a modest stipend during their internships. As the number of persons applying for internships has recently outpaced the number available in a given year, internship placement has become more competitive (Vasquez, 2011). The APA annually publishes a list of accredited clinical psychology programs and approved internship sites in its flagship journal, the *American Psychologist*.

TESTING OF COMPETENCE To be licensed as a clinical psychologist, candidates must declare to licensing boards their areas of competence, and they must pass a comprehensive examination, often called a *licensing board exam*, which may include both written and oral components. The written national licensing test used in the United States and Canada is called the *Examination for Professional Practice in Psychology* (EPPP). Passing this examination also makes it easier for clinicians to have their licenses recognized in a state other than the one where they were first licensed, a process called *reciprocity*. Some states require other examinations, particularly if candidates want to declare certain areas of competency.

GOOD CHARACTER Prospective clinical psychologists must show the physical, mental, and moral capability to engage in the competent practice of the profession. This characteristic is often denoted by letters of recommendations and by the absence of ethical or legal violations. Practitioners of clinical psychology should also know the *ethical codes* that guide practice: the American Psychological Association's *Ethical Principles of Psychologists and Code of Conduct* (2010). Referred to hereafter as the *Ethics Code*, this publication offers guidance on ethical concerns related to competence, human relations, privacy and confidentiality, record keeping, education and training, therapy, and many other situations. It is especially useful in navigating the gray areas that invariably come up in the practice of clinical psychology. Of course, all practitioners should know the obligations, freedoms, and limitations that go with practice under their level of licensure and in their state. Familiarity with the Ethics Code, as well as with state and federal laws, is necessary for these psychologists to be effective and to avoid professional mistakes that could have serious consequences.

Most clinical psychologists hold professional licenses and provide psychotherapy treatment, but as suggested earlier, not all do. Rather than specialize in assessment and treatment, some choose to engage primarily in some combination of teaching, research, consulting, or administration, while doing little or no direct service delivery. But non practicing clinical psychologists, too, must complete formal educational requirements and follow professional codes of conduct and regulations. For instance, clinical researchers must follow sections of the Ethics Code dealing with research in psychology, and their studies are overseen by *Institutional Review Boards*, which are established under federal guidelines to protect the rights and well-being of human participants in research.

Popularity of Clinical Psychology

Clinical psychology is the largest subfield of psychology. Graduate programs in clinical psychology attract more applicants than do graduate programs in any other area of psychology (see Figure 1.1), and far more doctoral-level degrees are awarded in clinical and related health service provider areas than in other areas of psychology (Kohout & Wicherski, 2011). The prominence of clinical psychology helps explain why the terms *psychologist* and *clinical psychologist* are practically synonymous in public discourse.

The appeal of clinical psychology is also reflected in the composition of the largest organization of psychologists in the United States: the American Psychological Association. Of the 56 divisions in APA, the largest divisions relate to clinical psychology (Division 12—Clinical Psychology, Division 40—Clinical Neuropsychology, and Division 42—Psychologists in Independent Practice). Of course, for students interested in clinical psychology, popularity means competition, especially for spots in graduate schools. Indeed, the stronger, research-oriented PhD programs, whose students typically score the highest on the Examination for Professional Practice in Psychology, accept as few as 7% of applicants, while some freestanding PsyD programs accept closer to 50% (Norcross, Ellis, & Sayette, 2010). Despite the competition, the outlook for clinical psychologists looks promising. The U.S. Department of Labor’s Occupational Outlook Handbook (2011) projects that job prospects for doctoral-level applied psychologists are best, while master’s degree holders will face keen competition and bachelor’s degree holders will find limited opportunities. CNN’s Money.com (2012) rates clinical psychologist as 23rd among the top 50 jobs in America, with personal satisfaction, job security, future growth, and benefit to society at high levels.

The field’s popularity is also shown by the numerous portrayals of clinical psychologists and their distressed clients in movies, television, and other media. This kind of popularity is a double-edged sword. On the one hand, accurate portrayals can contribute to the public’s *mental health literacy*—accurate understanding of psychological disorders and their treatments (Jorm, 2000). On the other hand, inaccurate portrayals can decrease mental health literacy and create inaccurate, stereotyped views of the profession. Unfortunately, the latter outcome seems to be more common. Clinical psychologists are often portrayed as oracles, agents of social compliance, or wounded healers, and the techniques by which they help clients are seldom portrayed accurately (Orchowski, Spickard, & McNamara, 2006). Inaccurate portrayals might make for good drama, but they don’t reveal what clinical psychology is really like. We hope that this book does a much better job.

Clinical Psychology and the Related Mental Health Professions

As noted earlier, clinical psychologists are considered *health service providers*. Other subfields within psychology belonging to this category include behavioral and cognitive psychology, clinical psychology, clinical child psychology, clinical health psychology, clinical neuropsychology, counseling psychology, family psychology, forensic psychology, professional geropsychology, psychoanalytic psychology, and school psychology (Nelson, 2013). Clinical services are also offered by professionals trained outside psychology in professions such as social work, psychiatry, and nursing. Like clinical

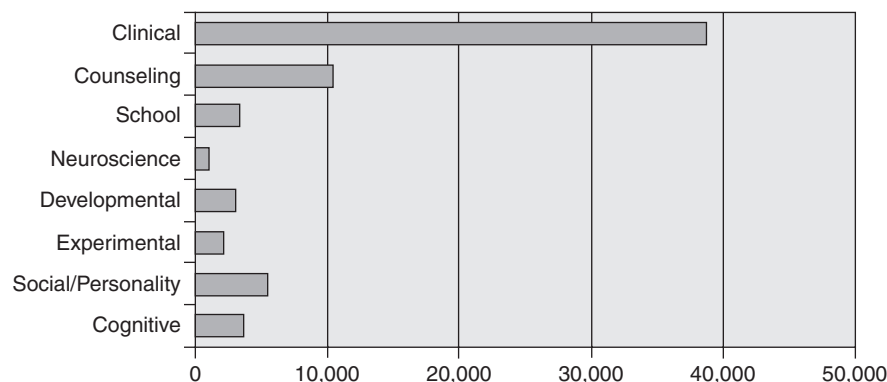


FIGURE 1.1 Applicants to U.S. Psychology Programs, 2009–2010. *Source:* Adapted from Kohout and Wicherski (2011).

psychology, each of the professions mentioned above has one or more national or international organizations, networks of accredited training programs, well-established research traditions, and specific licensing or certification requirements. Each group also has its own unique history and traditions. Practitioners from each group offer mental health services in one form or another. How then are clinical psychologists similar to, and different from, these other professionals?

COUNSELING PSYCHOLOGY Counseling psychologists are the most similar to clinical psychologists in their training and in the types of services that they offer. Much of their course work and supervised training overlaps with that of clinical psychologists—practitioners are trained in psychopathology, interviewing, assessment, counseling and psychotherapy, research, and the like. Students in the two fields apply to the same list of accredited internship sites, and graduates from the two subfields are eligible for the same licensure, practice opportunities, and insurance reimbursement. These two subfields are similar enough in their training, research interests, professional activities, and licensure requirements that calls to merge the two fields are often heard (Norcross, 2011). Nevertheless, there are a few salient differences between clinical and counseling psychology.

Clinical psychology programs are invariably housed in psychology departments, while counseling psychology programs are sometimes housed in psychology departments, but are often located in education departments or other departments or divisions. Counseling psychologists can earn a PhD, PsyD, or EdD degree, all doctoral-level degrees but differing in emphasis (discussed later in this chapter and in Chapter 15).

Counseling psychology was founded to promote personal, educational, vocational, and group adjustment (American Psychological Association Division 17, 2012). Accordingly, counseling psychologists are more likely to deal also with normal transitions and adjustments that people may face. Besides offering psychotherapy, counseling psychologists might, for instance, do career counseling or other forms of counseling related to life changes or developmental problems. Clinical psychology, on the other hand, was founded primarily to assess and treat persons with psychological disorders (see Chapter 2). Therefore, clinical psychologists focus more specifically on prevention, diagnosis, and treatment of psychological problems and on research related to these issues, and they generally deal with more severe pathology than counseling psychologists do. So the differences between clinical psychology and counseling psychology are largely a matter of emphasis. Despite these differences, there is considerable overlap between the professions.

SCHOOL PSYCHOLOGY School psychologists also have much in common with clinical and counseling psychologists: they generally share a scientist-practitioner model of training, move through similar internship and licensure requirements, conduct assessments, design interventions at the individual and system levels, and evaluate programs. The obvious difference is that school psychologists typically receive more training in education and child development, and they focus their interventions on children, adolescents, adults, and their families in school and other educational settings. Despite the differences in emphasis, the similarities to clinical, especially to clinical child psychology, and to counseling psychology are greater than the differences (American Psychological Association Division 16, 2012; Cobb et al., 2004).

SOCIAL WORK As the nation's largest group of mental health service providers, social workers are employed in a variety of settings, including hospitals, businesses, community mental health centers, courts, schools, prisons, and family service agencies. Students in social work programs may choose to specialize in direct services to clients, or they may specialize in community services (Ambrosino, Heffernan, Shuttlesworth, & Ambrosino, 2012). About half of the National Association of Social Workers members are engaged in offering direct clinical services, including various forms of therapy; the rest work in areas such as administration, public policy, research, and community organizing.

Social workers can earn a bachelor's degree (Bachelor of Social Work, or BSW), master's degree (Master of Social Work, or MSW), or doctoral degree (Doctorate in Social Work, or DSW or PhD). As in clinical psychology, licensing and certification laws vary by state. Typically, the minimum degree required to provide psychotherapy services is an MSW (National Association of Social Workers, 2012). Social workers may be trained in various psychotherapy techniques, but as a general rule, they focus more on how social/situational variables, rather than intrapersonal and interpersonal variables, affect functioning. Social workers, like clinical psychologists, spend much of their time in direct client contact, helping clients cope with problems and navigate a world that has become complex and difficult because of those problems.

PSYCHIATRY One of the first questions students ask when they begin studying psychology is “What’s the difference between a psychologist and a psychiatrist?” The most entertaining answer is: “about \$80,000 per year,” but the more comprehensive answer involves the differences in training and practice between the two professions. Psychiatry is a specialty within the medical field. So, just as pediatrics focuses on children, ophthalmologists specialize in eyes, and neurologists focus on the brain and nervous system, psychiatrists are medical doctors who specialize in treating psychological disorders. Persons training to be psychiatrists typically complete a psychiatric residency in which they take course work in psychology and undergo supervision by qualified psychiatrists as they work with patients. This residency often occurs in a hospital setting and therefore generally involves exposure to more serious psychopathology, but it may also occur in outpatient settings. Many psychiatrists offer psychotherapy, but not all do. According to recent surveys, the majority see patients for less than 25 minutes at a time, often for medication reviews (Kane, 2011). In addition to doing therapy and prescribing medication, psychiatrists order or conduct other medical tests, teach, do research, work in administration, and perform other tasks commensurate with their level of training. Though psychiatrists generally have more medical training than clinical psychologists, clinical psychologists typically have more formal training in psychological assessment and a broader exposure to a variety of approaches to psychology.

The historical distinction between psychiatrists and clinical psychologists has been understood as reflecting the difference between a more biological (psychiatrists) and a more psychological (clinical psychologists) view of the causes of mental disorders. Recent years, however, have seen increased collaboration between the professions. Much of the change can be attributed to the growing realization that psychological disorders are seldom *either* biological or psychological in origin but typically a complex interaction of both. As a result, clinical psychologists are increasingly employed in medical settings, where their psychological and research expertise are valued. Psychiatrists and psychologists often work cooperatively on task forces devoted to issues of valid diagnoses and effective treatments. This is consistent with a broader shift toward psychology becoming a health profession rather than strictly a mental health profession (Rozenky, 2011).

OTHER SPECIALTIES RELATED TO CLINICAL PSYCHOLOGY Mental health services are also offered by a variety of other *specialists* and *caregivers*. We have already mentioned counseling psychology and school psychology as two subfields that are closely related to clinical psychology. In Chapters 11–14, we detail four other specialties related to clinical psychology: clinical child psychology, health psychology, clinical neuropsychology, and forensic psychology. Other psychology programs that train *health service providers* include sport psychology, rehabilitation psychology, marriage and family therapy, humanistic psychology, and community counseling.

Still other specialists are trained outside psychology in programs specifically devoted to that specialty. For instance, as specialists within the nursing profession, psychiatric nurses usually work in hospital settings and operate as part of a treatment team that is headed by a psychiatrist and includes one or more clinical psychologists. They may be trained in some forms of therapy, often those specific to the populations they encounter. Pastoral counselors typically get training in counseling from a faith-based perspective. For clients whose religious faith is central to their identity and outlook on life, the availability of a counselor who affirms this faith can be important.

Paraprofessionals, psychological assistants, and others who go by similar names, are usually bachelor’s-level or associate-level personnel trained to administer a specific form of treatment to a specific population. They generally work as part of a treatment team, and their activities are supervised by professionals. Their training varies, but many come from disciplines that have some or all of the following indicators of professional quality: well-articulated standards of practice, national organizations that promote and oversee the profession, course offerings in colleges and universities, empirical research traditions, and peer-reviewed journals.

Others specialties, such as aromatherapy, reflexology, homeopathy, and spiritual healing techniques, have few or none of the indicators of professional quality just listed and might be described as further from the mainstream of mental health treatment. Often classified as *alternative treatments* or *alternative medicine*, many of these further-from-the-mainstream treatments combine somatic or sensual experiences with variants on psychological, social, or spiritual intervention. Some of these practices derive from ancient traditions; some are new inventions. Persons who practice alternative treatments often describe their work as falling within a *holistic* tradition that emphasizes the integration of mind, body, and spirit (Feltham, 2000).

SECTION SUMMARY

Clinical psychology involves the application of principles, methods, and procedures to reduce or alleviate maladjustment, disability, and discomfort in a wide range of client populations. Its title and practices are regulated by professional organizations and by state licensing boards. Specific kinds of training are required for the different types of licensure, and certain personal traits, such as a clinical attitude, sound judgment, and emotional stability, are needed to practice the profession effectively. As one of the health service provider professions, clinical psychology overlaps with other mental health professions but is distinguished by psychological training that is both research oriented and practical. It remains the most popular specialty within psychology, one of the most popular majors among undergraduates, and a profession, the practice of which is a source of considerable curiosity and interest in the public.

CLINICAL PSYCHOLOGISTS AT WORK

SECTION PREVIEW

Here we describe the various professional activities of clinical psychologists and how clinicians distribute their work time among those activities. We also describe the various employment settings and general salary ranges of clinical psychologists.

Activities of Clinical Psychologists

Let's consider in more detail some of the activities that clinical psychologists pursue, the variety of places in which they are employed, the array of clients and problems on which they focus their attention, and the rewards of the job. Not all clinicians are equally involved with all the activities we will describe, but our review should provide a better understanding of the wide range of options open to those who enter the field. It might also help explain why the field remains attractive to so many students.

About 95% of all clinical psychologists spend their working lives engaged in some combination of six activities: assessment, treatment, research, teaching (including supervision), consultation, and administration. Figure 1.2 shows the results of surveys taken over the last few decades examining how clinical psychologists spend their time. Keep in mind that the percentages vary considerably across work settings—psychologists in university settings will spend more time engaged in teaching and research, and those in private practice will spend more time conducting psychotherapy and assessment.

ASSESSMENT Assessment involves collecting 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 guide legal decisions regarding the commitment of individuals to institutions, to provide a more complete picture of a client's problems, to screen potential participants

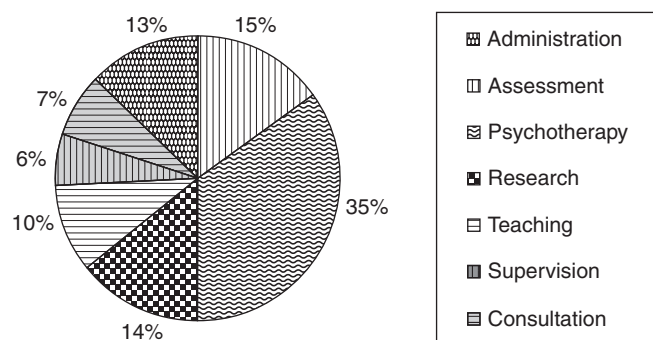


FIGURE 1.2 Percentage of Time Licensed Psychologists Spend in Professional Activities. *Source:* Based on Norcross, J. C., Karpiak, C. P., & Santoro, S. O. (2005). Clinical psychologists across the years: The Division of Clinical Psychology from 1960 to 2003. *Journal of Clinical Psychology, 61*, 1467–1483.

in psychological research projects, to establish pretreatment baseline levels of behavior against which to measure posttreatment improvement, and for literally hundreds of other purposes. Most clinical assessment instruments fall into one of three categories: tests, interviews, and observations. We cover each of these in detail in the chapters devoted to assessment.

Clinicians today have an array of assessment options not formerly available to them. For instance, computers can administer assessment items, analyze results, and generate entire written reports. Another frontier of psychological assessment is developing from research on a variety of biological factors associated with human functioning. During the last two decades, research focusing on genetic, neurochemical, hormonal, and neurological factors in the brain has led to the development of new neurobiological assessments. These changes, too, have the potential to greatly enhance the assessment efforts of clinicians, but as with computer-based assessment, they raise a number of procedural, practical, and ethical questions (Gazzaniga, 2011; Popma & Raine, 2006).

TREATMENT Clinical psychologists offer treatments designed to help people better understand and solve distressing psychological problems. These interventions are known as psychotherapy, behavior modification, psychological counseling, or other terms, depending on the theoretical orientation of the clinician. Treatment sessions may include client or therapist monologues, painstaking construction of new behavioral skills, episodes of intense emotional drama, or many other activities that range from the highly structured to the utterly spontaneous.

Individual psychotherapy has long been the single most frequent activity of clinicians (Kazdin, 2011), but psychologists may also treat two or more clients together in couple, family, or group therapy. Sometimes, two or more clinicians work in therapy teams to help their clients. Treatment may be as brief as one session or may extend over several years. Some psychologists, known as community psychologists, focus on preventing psychological problems by altering the institutions, environmental stressors, or behavioral skills of people at risk for disorder (e.g., teenage parents) or of an entire community. The results of psychological treatments are usually positive, though in some cases the change may be small, nonexistent, or even negative (Castonguay, Boswell, Constantino, Goldfried, & Hill, 2010; Lilienfeld, 2007). Of course, increasing the effectiveness of treatments offered to the public is a key goal of research. (Treatment outcomes are discussed in several later chapters, especially Chapter 10, “Research on Clinical Intervention.”)

RESEARCH By training and by tradition, clinical psychologists are research oriented. For most of the first half of its existence, the field was strongly dominated by research rather than by application (see Chapter 2). Although that balance has changed, research continues to play a vital role in clinical psychology.

Research activity makes clinicians stand out among other helping professions, and we believe it is in this area that they may make their greatest contribution. In the realm of psychotherapy, for example, theory and practice were once based mainly on case study evidence, subjective impressions of treatment efficacy, and rather poorly designed research. This “prescientific” era (Paul, 1969) in the history of psychotherapy research has 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. This development is due in large measure to the research of clinical psychologists.

Clinical research varies greatly with respect to its setting and scope. Some studies are conducted in research laboratories, while others are conducted in the more natural, but less controllable, conditions outside the lab. Some projects are supported by governmental or private grants that pay for research assistants, computers and other costs, but a great deal of clinical research is performed by investigators whose budgets are limited and who depend on volunteer help and their own ability to obtain space, equipment, and participants.

Clinical psychology’s tradition of research is reflected in graduate school admission criteria, which often emphasize applicants’ grades in statistics or research methods over grades in abnormal psychology or personality theory. Many graduate departments in psychology in the United States regard research experience as among the three most important criteria for admission, and graduates of research-oriented clinical psychology programs typically outperform graduates of programs that don’t emphasize research as much (Norcross, Ellis, & Sayette, 2010; Pate, 2001). Even though most clinical psychologists do not end up pursuing a research career—many never publish a single piece of research—most graduate programs in clinical psychology still devote a significant amount of time to training in empirical research. Why?

There are at least four reasons. First, it is important that all clinicians be able to critically evaluate published research so that they can determine which assessment procedures and therapeutic interventions are likely to be effective. Second, clinicians who work in academia must often supervise and evaluate research projects conducted by their students. Third, when psychologists who work in community mental health centers or other service agencies are asked to assist administrators in evaluating the effectiveness of the agency's programs, their research training can be very valuable. Finally, research training can help clinicians objectively evaluate the effectiveness of their own clinical work. Tracking client change can signal the need to change treatment plans, reveal the need for additional clinical training, and contribute to third party (e.g., insurance companies, clinical researchers) efforts to document and understand factors affecting clinical effectiveness (Hatfield & Ogles, 2004).

TEACHING A considerable portion of many clinical psychologists' time is spent in educational activities. Clinicians who hold full- or part-time academic positions typically teach undergraduate and graduate courses in areas such as personality, abnormal psychology, introductory clinical psychology, psychotherapy, behavior modification, interviewing, psychological testing, research design, and clinical assessment. They conduct specialized graduate seminars on advanced topics, and they supervise the work of graduate students who are learning assessment and therapy skills in practicum courses.

A good deal of clinical psychologists' teaching takes the form of research supervision. This kind of teaching begins when students and professors discuss research topics of mutual interest that are within the professor's area of expertise. Most research supervisors help the student frame appropriate research questions, apply basic principles of research design to address those questions, and introduce the student to the research skills relevant to the problem at hand.

Clinical psychologists also do a lot of teaching in the context of in-service (i.e., on-the-job) training of psychological, medical, or other interns, social workers, nurses, institutional aides, ministers, police officers, prison guards, teachers, administrators, business executives, day-care workers, lawyers, probation officers, and many other groups whose vocational skills might be enhanced by increased psychological sophistication. Clinicians even teach while doing therapy—particularly if they adopt a behavioral approach in which treatment includes helping people learn more adaptive ways of behaving (see Chapter 8). Finally, many full-time clinicians teach part time in colleges, universities, and professional schools. Working as an adjunct faculty member provides another source of income, but clinicians often teach because it offers an enjoyable way to share their professional expertise and to remain abreast of new developments in their field.

CONSULTATION Clinical psychologists often provide advice to organizations about a variety of problems. This activity, known as consultation, combines aspects of research, assessment, treatment, and teaching. Perhaps this combination of activities 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. Consultants perform many kinds of tasks, including education (e.g., familiarizing staff with research relevant to their work), 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).

When consulting is *case* oriented, the clinician focuses attention on a particular client or organizational problem and either deals with it directly or offers advice on how it might best be handled. When consultation is *program* or *administration* oriented, the clinician focuses on those aspects of organizational function or structure that are causing trouble. For example, the consultant may suggest and 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.

ADMINISTRATION Many clinical psychologists find themselves engaged in managing or running the daily operations of organizations. Examples of the administrative posts held by clinical psychologists include head of a college or university psychology department, director of a graduate training program in clinical psychology, director of a student counseling center, head

of a consulting firm or testing center, superintendent of a school system, chief psychologist at a hospital or clinic, director of a mental hospital, director of a community mental health center, manager of a government agency, and director of the psychology service at a Veterans Administration (VA) hospital. Administrative duties tend to become more common as clinicians move through their professional careers.

Although some clinical psychologists spend their time at only one or two of the six activities we have described, most engage in more, and some perform all six. To many clinicians, the potential for distributing their time among several functions is one of the most attractive aspects of their field.

Employment Settings of Clinical Psychologists

At one time, most clinical psychologists worked in a single type of facility: child clinics or guidance centers. Today, however, the settings in which clinicians function are much more diverse. You will find clinical psychologists in the following as well as many other settings:

college and university psychology departments	institutions for the intellectually disabled
law schools	police departments
public and private medical and psychiatric hospitals	prisons
city, county, and private mental health clinics	juvenile offender facilities
community mental health centers	business and industrial firms probation departments
student health and counseling centers	rehabilitation centers for the handicapped
medical schools	nursing homes and other geriatric facilities
the military	orphanages
university psychological clinics	alcoholism treatment centers
child treatment centers	health maintenance organizations (HMOs)
public and private schools	

The work settings that clinical psychologists choose strongly influence how they distribute their time across professional activities. But so do their training, individual interests, and areas of expertise. Work activities are also influenced by larger social factors. For example, a clinician could not work in a Veterans Administration hospital today if federal legislation had not been passed in the 1940s creating such hospitals. (The role played by sociocultural forces in shaping clinical psychology is more fully detailed in Chapter 2.) In short, what clinicians do and where they do it has always depended—and always will depend—on situational demands, cultural values, changing political climates, and the pressing needs of the society in which they function. Table 1.1 shows the primary and secondary work settings of health service providers in psychology, the majority of which are clinical psychologists.

TABLE 1.1 Primary and Secondary Work Settings of APA-Affiliated Health Service Providers

Setting	Primary Setting (%)	Secondary Setting (%)
Independent private practice		
Individual	36	37
Group	10	9
Hospitals	12	6
Other human service settings	11	11
Managed care	5	3
Business and government	7	9
Academic	19	25

Source: Michalski and Kahout (2011).

Salaries of Clinical Psychologists

The financial rewards for employment as a clinical psychologist are significant. A 2010 report by the APA Center for Workforce Studies showed that the overall 11–12-month median salary for licensed doctoral-level clinical psychologists was \$87,015. As you no doubt have guessed, salary levels vary according to employment setting, years of experience, and economic conditions. Table 1.2 presents the median as well as the 25th and 75th percentile (Q1 and Q3, respectively) salaries for clinical psychologists in a variety of settings. These figures should give you an idea of salary ranges for clinical psychologists.

The APA periodically surveys its members concerning salaries, demographics, practice concerns, and many other topics, and then makes the results public. Much of that information can be accessed at APA's Web site: <http://www.apa.org> (though some information is available only to APA members).

TABLE 1.2 Salaries of Licensed Doctoral-Level Clinical Psychologists in Direct Human Service Positions

Setting and Years of Experience	Median, 25th, and 75th Percentile Salaries		
	Median	Q1	Q3
Individual Private Practice			
10–14 years	82,733	64,028	125,000
20–24 years	89,000	65,000	120,000
Group Psychological Practice			
10–14 years	90,000	68,000	120,000
20–24 years	95,000	75,000	130,000
Primary Care Group Practice			
15–19 years	88,000	40,000	159,000
20–24 years	96,500	79,900	129,715
VA Medical Center			
15–19 years	102,000	91,000	112,228
20–24 years	104,000	85,500	114,500
Public General Hospital			
10–14 years	80,500	65,000	87,125
20–24 years	85,000	65,000	97,000
University Student Counseling Center			
10–14 years	58,900	50,000	67,250
20–24 years	63,500	52,145	79,000
Elementary or Secondary School			
10–14 years	NA	NA	NA
20–24 years	94,278	74,250	128,639
Community Mental Health Center			
15–19 years	69,950	60,500	90,750
25–29 years	72,500	69,196	103,250
Criminal Justice System			
15–19 years	80,000	51,000	107,160
20–24 years	80,500	75,000	103,000
Federal Government Agency			
10–14 years	99,000	94,750	99,833
15–19 years	99,050	82,375	112,500

Note: NA = not available.

Source: Finno, Michalski, Hart, Wicherski, and Kohout (2010)

Diversity Among Clinical Psychologists

The workforce in clinical psychology has become more diverse over the years. In 1950, for instance, women earned only 15% of the doctoral degrees awarded in psychology, but since that time, there has been a dramatic reversal in the gender distribution. As illustrated in Figure 1.3, women made up a third of new clinical doctoral degrees in 1976, but by 2010 they made up over 70% of earned clinical doctorates (Michalski, 2009; National Center for Education Statistics, 2000; Pate, 2001; Rozell et al., 2011; Sayette et al. 2011). This percentage is quite similar in both more practice-oriented and more research-oriented programs. A survey of student gender distribution in clinical psychology programs showed that in European countries, too, women outnumber men, often by wide margins (Olos & Hoff, 2006).

Of course, there is a lag of several years between enrollment in a degree program and the attainment of senior status within a profession. As a result, there are still more men than women among senior clinical psychology faculty in colleges and universities and more men than women among the higher-salary private practitioners of clinical psychology. But at all levels, there is a clear trend toward greater representation of women, and there are now more women than men in the health service provider workforce (58% versus 42%; Michalski & Kohout, 2011).

Ethnic minorities currently make up approximately 20% of the new doctoral degrees in clinical psychology, up from about 8% in 1977. While this is a positive trend, the overall pace of change in minority representation has been slow, with percentages of minorities hovering around 20% for nearly a decade (Michalski, 2009; Rozell et al., 2011). African Americans represent the highest percentage of minorities in all psychology graduate programs, followed by persons of Hispanic and Asian origin and Native Americans. Many colleges and universities have specific recruitment plans for targeting persons of color, and many psychology departments have their own department-level strategies for recruiting minorities. Examples of such efforts include outreach programs to “feeder” undergraduate schools, financial assistance to minorities, brochures or other materials geared toward persons of color, and involvement of more persons of color in the recruitment and screening process.

The median age of recent doctorates in clinical psychology is 32. That may seem old (or perhaps “mature” is a better word) to students approaching or just finishing their bachelor’s degrees, but it can be accounted for by a couple of factors. First, many people enter doctoral programs after having worked in the field for several years with a master’s or bachelor’s degree. Second, it takes years to complete a doctoral degree. While most students complete a clinical doctorate in 5–6 years, some take 7 or 8 years or more. Keep in mind that during a significant portion of this time, most students are working, at least part time, and earning a wage, and this invariably slows down progress toward completion (but it helps to pay the bills).

Finally, clinical psychologists vary in terms of their sexual orientation. In the most recent survey of the workforce, about 91% of health service providers identified themselves as heterosexual, while 7% identified themselves as gay, lesbian, bisexual, or transgendered (a small percent did not respond to this part of the survey). These percentages are close to the percentages researchers typically find in surveys of sexual orientation in the general population (Weiten, 2011), though

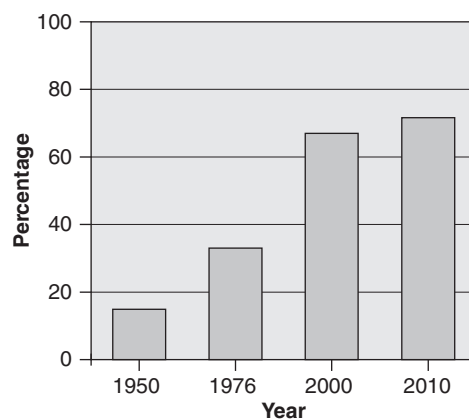


FIGURE 1.3 Percent of Women Earning Doctorates in Clinical Psychology. Sources: National Center for Education Statistics, 2000; Pate, 2001; Rozell, Berke, Norcross, and Karpiak, 2011; Sayette, Norcross, and Dimoff, 2011.

such percentages vary according to how questions are asked and whether responses are simply categorized or measured on a scale that allows variation across a continuum (see Epstein, 2007).

Diversity Among Clients

Clinical psychologists in the United States and Canada can expect to see increasing diversity in their clients too. By 2050, non-Hispanic whites are expected to be 50% of the U.S. population with ethnic minorities making up the other half. A greater proportion of Americans will have been born in other countries, or will have parents who were, than has been the case for decades. How does this diversity affect clinical psychology?

For one thing, persons from different backgrounds often have different ways of expressing psychological distress, so clinicians have become increasingly sensitive to cultural variations in symptoms (Hays & Iwamasa, 2006). Responses to treatments can also vary depending on clients' backgrounds. Even willingness to seek psychological help varies by cultural and ethnic background. Clinicians will therefore need additional training in order to provide culturally sensitive services to diverse groups (Hall, 2005).

Clients will be diverse not only in their demographics, but also in the types of problems they bring to clinical psychologists. Which are the most common problems? The National Comorbidity Survey (1990–1992) and National Comorbidity Survey Replication (2001–2003) are among the largest studies to try to examine the general population prevalence and severity of psychological disorders. They show that anxiety disorders (e.g., panic disorders, social phobia), mood disorders (e.g., depression), impulse-control disorders (e.g., intermittent explosive disorder), and substance disorders (e.g., alcohol abuse, drug abuse) are among the most common. Yet only about half of those who receive treatment actually meet the criteria for a diagnosable mental disorder (Kessler et al., 2005). The remainder have symptoms that do not quite fit the current diagnostic criteria (discussed in Chapter 3). Such problems include difficulties in interpersonal relationships, marital problems, school difficulties, psychosomatic and physical symptoms, job-related difficulties, and so on. The prevalence and types of problems for which people seek help have remained similar over the years, suggesting that the need for clinical psychologists has not declined, even though the cultural backgrounds of clients who experience those problems have become more diverse. The bottom line is that cultural competence has become a requirement for clinical psychologists (Sehgal et al., 2011). In numerous places throughout this book, we describe how personal, ethnic, and cultural diversity affects clinical practice.

SECTION SUMMARY

Clinical psychologists spend most of their professional time engaged in assessment, psychotherapy, research, teaching, consultation, and administration. The activities in which they engage, and the clients they see, are strongly affected by employment settings, personal preferences, training, and broader social factors. Clinicians are employed in a variety of settings, including individual and group practices, hospitals of various types, community mental health centers, college and university psychology departments and medical schools, government agencies, private corporations, and others. In those settings, they see clients from a variety of cultural backgrounds and with a variety of problems. Clinicians' salaries vary by level of training, employment setting, and regional factors but are on par with many other professions with similar levels of training. Once dominated by white males, the field now has a higher percentage of women and ethnic minorities than in the past.

CLINICAL PSYCHOLOGY IN THE 21ST CENTURY

SECTION PREVIEW

Here we outline some of the more prominent issues shaping clinical psychology today. The first of these relates to the need to balance science and practice within the field. Other key issues concern how clinicians should be trained, how the traditionally separate "schools" or theoretical orientations within clinical psychology might be brought together, and how the practice of clinical psychology has been affected by the social and cultural environment, particularly by the way managed care and legislation have changed health care delivery.

Science and Practice

Some of the liveliest discussions within clinical psychology involve the extent to which the field should reflect the concerns of its scientists and its practitioners. If scientists/researchers hold one viewpoint but practitioners hold another, whose view should prevail? There is a long history to this topic, and here we introduce only the broad outlines and suggest some of its major implications. Later, especially in Chapters 2, 10, and 15, we detail the various positions and work through their implications for the field.

We have already noted that the official definition of clinical psychology incorporates both science and practice. The question is: *how* should science and practice be combined? This seemingly simple question goes well beyond mere philosophical or academic debate. It affects how clinicians are trained, how clients are treated, how research is conducted, and how others view psychological interventions.

EVIDENCE-BASED PRACTICE Imagine going to a physician who was unaware of, or who chose to disregard, the last two decades of medical research results and relied instead on intuition, outdated training, and folklore to decide what treatments to provide. If you wanted state-of-the-art treatment, you probably would not go back to that doctor. Basing professional practice on solid, up-to-date research is referred to as *evidence-based practice* (EBP). The idea is that rather than rely on the best guesses of individuals or on “the way it’s always been done,” practitioners should use those diagnostic and therapeutic practices that the best scientific evidence finds most effective.

Clearly, evidence-based practice is an idea whose time has come, and no reasonable person doubts that clinical psychologists should base their practice on the results of high-quality scientific research. The problem is that the field lacks a clear consensus on which research is of the highest quality, what it shows, and exactly how it should guide practice. In short, different groups within the APA have different understandings of what evidence-based practice means. Our own perspective, which we detail in Chapter 10, is that both empirical evidence and clinical experience are crucial for evaluating the usefulness of different psychological interventions. Clinical experience is invaluable as a starting point for generating hypotheses about what makes psychotherapy effective, but if certain therapy techniques underperform in repeated clinical trials, those techniques should be abandoned in favor of techniques that perform better.

There is some urgency in the field’s reaching consensus about what constitutes the best evidence and how to train and update clinicians in the best practices. Some local and state agencies and some insurance providers have constructed lists of the psychotherapies for which they will provide reimbursement to patients (Norcross, Beutler, & Levant, 2006). They do so on the basis of *their* understanding of the research and of their needs, not on the basis of official positions taken by clinical psychologists. Presumably, clinical researchers and practitioners should have more expertise in these matters, and many believe that they and their official organizations should be more active in listing which psychotherapies are most effective.

Fortunately, the urgency of establishing best practices (while recognizing that research and practice are continually evolving) is being recognized. Indeed, the term “evidence-based” has become a rallying cry that is widely shared, even among people who may disagree about exactly what it means. Consider, for example, that a search of APA’s PsychScan clinical psychology database (which surveys journals related to clinical psychology) from the years 1990 to 2000 yielded a total of eight articles with the term “evidence-based” in the titles. Between 2000 and 2011 there were 206 hits. Lately, numerous authors have suggested ways to better align research and practice (see Goodheart, 2011; Kazdin, 2011). And in 2010, the American Psychological Association initiated a process to develop evidence-based treatment guidelines, the first time that organization has sought to develop recommendations for treatments for specific disorders (Kurtzman & Bufka, 2011).

CLINICAL PSYCHOLOGY TRAINING Decisions about the most desirable mix of science and practice also affect how students are trained in clinical psychology (and how textbooks such as this one are written!). There are two general models upon which clinical psychology training is based. Both are named after Colorado cities that hosted conferences where those models were developed. The *Boulder model* came out of clinical psychology’s first major training conference, held in 1949 (Raimy, 1950). Often referred to as the *scientist-practitioner* model, the Boulder model recommended that clinical psychologists be proficient in research and professional practice, earn

a PhD in psychology from a university-based graduate program, and complete a supervised, year-long internship.

In 1973, the National Conference on Levels and Patterns of Professional Training in Psychology was held at Vail, Colorado. The resulting *Vail model* recommended alternative training that placed proportionately less emphasis on scientific training and more on preparation for the delivery of clinical services (Korman, 1976). The Vail delegates also proposed that when training emphasis is on the delivery and evaluation of professional services, the PsyD would be the appropriate degree. They suggested, too, that clinical psychology training programs could be housed not only in universities but also in medical schools or in free-standing schools of professional psychology (such as those in California, Illinois, and other states), and that these independent schools should have status equal to that of more traditional scientist-professional training venues. We discuss these models of clinical training in more detail in Chapter 15. For now, perhaps the most important thing to remember about the differences among the various types of clinical psychology training is that programs vary widely in their application processes, costs, training orientations, and outcomes (Ameen & El-Ghoroury, 2013; Norcross, Ellis, & Sayette, 2010; Sayette Norcross, & Dimoff, 2011). We do not yet know for certain which of these, if any, affect outcomes for clients, but it is vital that we learn.

Eclecticism and Integration

Most of the clinical psychologists engaged in practice, research, and teaching today were trained in programs that emphasized one main theoretical orientation, such as psychodynamic, cognitive-behavioral, humanistic, family/systems, and the like. Is this the best way to organize clinical psychology training? Some have expressed concerns that a theory-based approach to clinical education has created such divisiveness within the field that those who have pledged allegiance to one orientation too often reflexively dismiss research and theory supporting other approaches (Gold & Strickler, 2006). This reaction is problematic because there is seldom a compelling empirical reason to adhere to only one theoretical approach; they all have their strengths and weaknesses. As a result, many clinical psychologists now favor *eclecticism*, an approach in which it is acceptable, and even desirable, to employ techniques from a variety of “schools” rather than sticking to just one.

Eclecticism is closely related to the idea of *psychotherapy integration*, the systematic combining of elements of various clinical psychology theories. In our view, it makes sense to combine approaches in reasonable ways rather than to strictly segregate them. If assessment and therapy techniques are tools, it is easy to see that possessing a wide range of tools, and knowledge of when and how to use them makes for an effective psychotherapist. Indeed, most therapists now identify themselves as *eclectic* (Santoro, Kister, Karpiak, & Norcross, 2004), and there is now a journal—the *Journal of Psychotherapy Integration*—devoted to integrating various therapy approaches.

But integration and eclecticism are not as easy to achieve in practice as they are in theory. How should theories and practices be combined? Might clinicians be better off trying to understand clients’ problems within one reasonably coherent theoretical orientation rather than with a multitude of orientations, some of which may feature conflicting assumptions? Chapter 9 describes some of the answers to these questions.

The Health Care Environment

Like all other professions, clinical psychology is shaped partly by the culture in which it operates. Popular beliefs and attitudes affect how mental health concerns are perceived, how problems are treated, and how treatment is funded. The last few years have seen significant changes in the health care laws affecting clinical psychology practice.

MENTAL HEALTH PARITY In 2008, the Mental Health Parity and Addiction Act (MHPAA) became law. Mental health parity requires that health insurers provide the same level of coverage for mental illness as they do for physical illness. Prior to 2008, parity had been the exception rather than the norm in U.S. health care. In other words, mental health problems have been regarded as less deserving than other health problems, and people were seen as more responsible for their psychological problems than for their medical problems.

This belief might have been easier to maintain a century ago when the most severe physical ailments were infectious diseases—smallpox, typhoid, diphtheria, for example—and when theories about the causes of mental illness did not incorporate interactions of biological, psychological, and social factors. But few people knowledgeable about psychological disorders today argue that

persons simply choose to have a psychological problem. At the same time, many of today's most urgent physical problems—heart disease, obesity, diabetes, for example—are related to lifestyle choices that people make. In short, people probably do not choose to be psychologically ill any more, or any less, than they choose to be physically ill, but disparities in health coverage can suggest that they do. Fortunately, there are signs that this pattern is changing, though negative attitudes toward mental health treatment have certainly not disappeared.

MANAGED CARE Clinical psychology training, practice, and research are all affected by how health care is structured. Whereas clients once paid providers directly for services, now most health care, including mental health care, involves three parties: client, clinician, and an insurance company, HMO, or similar organization. When the third-party organization influences who provides service, which treatments are used, how long treatments last, how much providers are paid, what records are kept, and so on, it is called *managed care*. Managed care systems use business principles, not just clinicians' judgments, to make decisions about treatment.

As managed care systems in the United States have grown and exerted their influence over psychological treatments, clinicians have had to adapt. In one study, clinicians reported a culture clash between themselves and the managed care companies, complaining that they sometimes had to violate standards of care or ethical standards in order to be paid (Cohen, Marecek, & Gillham, 2006). Managed care's influence helps explain why the salary discrepancy between private practice and other areas of clinical work is now smaller than it used to be. No wonder, then, that in general, clinicians dislike managed care.

Although the relationship between managed care and clinical psychology has sometimes been rocky, as it has between managed care and other health professions, it is not entirely negative (Bobbitt, 2006; Wilson, 2011). One positive effect of health care changes has been to stimulate research into which treatments are most effective for which problems; another is to put more emphasis on prevention (Silverman, 2013). It is in the interest of clients, clinicians, *and* insurers to know which interventions have the most positive and lasting impact on health, because that information, correctly applied, will ultimately lower costs and improve client well-being. The influence of managed care is also partly responsible for the pressure on clinicians to more precisely measure the outcome of the treatments they provide.

Clinical psychologists are continuing to adapt, often changing services to better match those for which managed care systems will pay. This adaptability makes sense, but it can lead to problems if psychologists simply allow managed care personnel to make decisions about clinical practice. Those with the most training and expertise should be in the best position to provide empirical evidence about what works best and what should be reimbursed.

PRESCRIPTION PRIVILEGES FOR CLINICAL PSYCHOLOGISTS A final aspect of the health care environment is the movement for clinical psychologists to be able to prescribe drugs. In 2002, New Mexico became the first state to pass legislation that permitted licensed psychologists with specialized training to prescribe psychotropic medications. In 2004, Louisiana followed, and prescription privileges now exist and in the military and Indian Health Services. There are several reasons that many think this trend will continue. One is the increasing public acceptance of medications for psychological problems, fueled in part by pervasive television and print advertising by drug companies. Another is that clinical psychologists deal extensively with persons taking certain medications. As a result, those psychologists are sometimes as knowledgeable, if not more so, about the effects of these drugs as the general practice physicians who referred the clients. Prescription privileges make sense also because psychologists see clients regularly, so they are often in a better position to monitor the effectiveness of the medications.

However, there are also arguments against prescription privileges, some coming from clinical psychologists themselves. One concern is that as prescription privileges expand, clinicians may prescribe drugs more and offer psychotherapy less. If this happens, and there is some evidence that it might, then clients would receive less of the services for which clinical psychology is best known, services that help clients develop coping and problem-solving skills that they can apply in the future (Nordal, 2010). Suffice it to say that the prescription privileges debate continues, and we discuss the pros and cons in Chapter 15.

MODELS OF TREATMENT DELIVERY As the previous discussion indicates, clinical psychologists have worked hard to identify the most effective treatments, and they have promoted the preferential use of these evidence-based treatments, for instance, via publication of practice guidelines.

Compared with a decade ago, the evidence base for psychological interventions is much stronger. However, the primary method of delivering psychological services to clients is still individual, face-to-face psychotherapy. Some have questioned whether this should change. For example, Kazdin (2011) argues that in-person one-on-one psychotherapy may not be the most effective model. He advocates models of treatment delivery that optimize the benefits of psychological interventions across broader segments of the population. This is especially pressing because in any given year, approximately 25% of the population meets the criteria for one or more psychological disorders and the majority of people in need of psychological services still do not receive them (Kessler & Wang, 2008).

More effective treatment delivery would still include one-on-one psychotherapy, but also other approaches. Those less likely to use in-person one-on-one psychotherapy would especially benefit from interventions delivered via technologies. For instance, television and telephone-based interventions, interactive computer-based or cellphone-based interactions, computer-based virtual reality treatments, and social media interventions have all been used to expand how clinical psychologists provide services (Harwood et al., 2011; Kazdin, 2011; Miller, 2013). Greater attention to supply and demand could also improve public psychological health. For example, psychological services are typically clustered in metropolitan areas, so greater attention to the needs of rural areas might also help underserved populations (Jameson, Blank, & Chambliss, 2009). We discuss alternate modes of clinical intervention, along with their ethical and clinical implications, more in Chapter 9.

SECTION SUMMARY

Clinical psychology combines science and practice, but the appropriate mix of the two is a matter of a debate that has intensified as the need to establish clear evidence-based practices in clinical psychology has grown. That need comes both from within the profession and from outside organizations that fund and pay for clinical services. In light of changes within the profession and within the broader society, clinical psychologists continue to examine their training models, particularly the dominant models that lead to PhD and PsyD degrees. They have also had to think more carefully about ways to integrate and combine various approaches to psychotherapy and assessment, as well as ways to deliver services. It has become clear that the turf wars among adherents of different approaches do not benefit the profession. Managed care organizations have influenced clinical practice and will continue to do so. Cultural and legal factors affect the field as well, as exemplified by the fate of legislation requiring mental health parity and that permitting prescription privileges for clinicians.

Chapter Summary

Clinical psychology is the largest single subfield within the larger discipline of psychology. It involves research, teaching, and other services designed to understand, predict, and alleviate maladjustment and disability. To become a licensed clinical psychologist, one must meet certain educational, legal, and personal qualifications. As one of the core health service provider professions, clinical psychology is distinguished from other helping professions by the clinical attitude: the tendency to use the results of research on human behavior in general to assess, understand, and assist particular individuals. The discipline is also distinguished by its emphasis on empirical research and by its diversity in training and practice.

That diversity can be seen in how clinicians distribute their time among six main functions: assessment, treatment, research, teaching, consultation, and administration. It can also be seen in

the increasing diversity of clinical psychologists themselves, and in the diversity of the population in need of mental health care. Clinical psychologists are employed in many different settings, from university psychology departments and medical clinics to community mental health centers and prisons. Many are self-employed private practitioners.

Clinical psychology faces numerous challenges, not the least of which is that most people with psychological problems still do not receive treatment. Other factors shaping the discipline involve, among other issues, decisions about how science and practice should be combined, how training of new psychologists should be conducted, how the various theoretical approaches can be integrated, and how the current (and future) systems of health care delivery affect the practice of clinical psychology.

Study Questions

1. Define clinical psychology.
2. What are the general licensure or certification requirements to be a clinical psychologist?
3. What educational and degree options are available for someone who wants to go into clinical psychology?
4. What personal and ethical criteria are needed to be a good clinical psychologist?
5. How are clinical psychologists similar to and different from counseling psychologists, school psychologists, psychiatrists, social workers, and other mental health professionals?
6. How do clinical psychologists spend most of their work time?
7. How does their work setting influence the way clinicians spend their time?
8. What are the salary ranges for clinical psychologists?
9. How have differing opinions about the balance of science and practice influenced the way psychotherapists operate and how graduate schools educate?
10. What is the eclectic approach to psychopathology and treatment?
11. How might integration of different theoretical approaches be possible?
12. How does cultural diversity influence approaches to psychological treatment?
13. How has managed care influenced clinical psychology research, training, and practice?
14. What is mental health parity?
15. What are the pros and cons associated with specially trained clinical psychologists being able to prescribe certain kinds of drugs?

Web Sites

- American Psychological Association (APA): <http://www.apa.org>
- Division 12 of the APA, the Society for Clinical Psychology: <http://www.div12.org/>
- Division 16 of the APA, School Psychology: <http://www.apa.org/about/division/div16.html>
- Division 17 of the APA, the Society for Counseling Psychology: <http://www.apa.org/about/division/div17.html>
- American Psychiatric Association: <http://www.psych.org>
- National Association of Social Workers: <http://www.socialworkers.org>
- American Psychiatric Nurses Association: <http://www.apna.org>

MOVIES

Shrink (2009): Somber film about a troubled therapist who has a best-selling self-help book and a growing drug addiction, with limited abilities to help his troubled clients.

What about Bob? (1991): Amusing and apocryphal film of a client who seeks to be close to his therapist and his therapist's family, while the therapist seeks to be rich and famous.

MEMOIRS

A Piece of Cake: A Memoir by Cupcake Brown (2006; Three Rivers Press). This memoir describes many of the issues that clinical psychologists deal with, including child abuse, sexual assault, substance abuse, forensic issues, poverty, and eventual resilience to overcome these challenges.

Undercurrents: A Therapist's Reckoning With Her Own Depression (1995; New York: Harper Collins). Through her own actual diary entries, this clinical psychologist shows her own personal descent into severe depression—including a moment when she was assessing a client for depression and realized that she met the criteria herself.

References

- Ambrosino, R., Heffernan, J., Shuttlesworth, G., & Ambrosino, R. (2012). *Social work and social welfare: An introduction*. Belmont, CA: Brooks/Cole.
- Ameen, E., & El-Ghoroury, N. (2013). Are you prepared for graduate school? *Psychology Student Network*. Retrieved Mar 19, 2013 from <http://www.apa.org/ed/precollege/psn/2013/01/graduate-school.aspx>.
- American Psychological Association (2010). *Ethical principles of psychologists and code of conduct*. American Psychological Association.
- American Psychological Association, Division 12 (2012). *About clinical psychology*. Retrieved Jan 1, 2012 from <http://www.apa.org/divisions/div12/abouttcp.html>.
- American Psychological Association, Division 16 (2012). *About school psychology*. Retrieved Jan 1, 2012 from <http://www.apa.org/divisions/div12/abouttcp.html>.
- American Psychological Association, Division 17 (2012). *About counseling psychology*. Retrieved Jan 1, 2012 from <http://www.apa.org/divisions/div17/abouttcp.html>.
- Bobbitt, B. L. (2006). The importance of professional psychology: A view from managed care. *Professional Psychology: Research and Practice*, 37, 590–597.
- Brown, T. A., & Barlow, D. H. (2001). *Casebook in abnormal psychology* (2nd ed.). Belmont, CA: Wadsworth.
- Castonguay, L. G., Boswell, J. F., Constantino, M. J., Goldfried, M. R., & Hill, C. E. (2010). Training implications of the harmful effects of psychological treatments. *American Psychologist*, 65, 34–39.
- CNNMoney (2012). *Best jobs in America*. Retrieved from <http://money.cnn.com/magazines/moneymag/bestjobs/2009/snapshots/23.html>.
- Cobb, H. C., Reeve, R. E., Shealy, C. N., Norcross, J. C., Schare, M. L., et al. (2004). Overlap among clinical, counseling, and school psychology: Implications for the profession and combined-integrated training. *Journal of Clinical Psychology*, 60, 939–955.
- Cohen, J., Marecek, J., & Gillham, J. (2006). Is three a crowd? Clients, clinicians, and managed care. *American Journal of Orthopsychiatry*, 76, 251–259.

- Epstein, R. (2007). Sexual orientation lies smoothly on a continuum: Verification and extension of Kinsey's hypothesis in a large-scale internet study. *Scientific American*, October, 6.
- Feltham, C. (2000). What are counselling and psychotherapy? In C. Feltham & I. Horton (Eds.), *Handbook of counselling and psychotherapy*. London, United Kingdom: Sage.
- Finno, A. A., Michalski, M., Hart, B., Wicherski, M., & Kohout, J. L. (2010). Report of the 2009 APA Salary Survey. Retrieved Dec, 28, 2011 from <http://www.apa.org/workforce/publications/09-salaries/index.aspx?tab=4>.
- Gazzaniga, M. (2011) *Who's in charge: Free will and the science of brain*. New York, NY: Harper Collins.
- Gold, J., & Strickler, G. (2006). Introduction: An overview of psychotherapy integration. In G. Strickler & J. Gold (Eds.), *A casebook of psychotherapy integration*. Washington, DC: American Psychological Association.
- Goodheart, C. D. (2011). Design for tomorrow. *American Psychologist*, 66, 339–347.
- Hall, G. C. N. (2005). Introduction to the special section on multicultural and community psychology: Clinical psychology in context. *Journal of Consulting and Clinical Psychology*, 73, 787–789.
- Harwood, T. M., Pratt, D., Beutler, L. E., Bongar, B. M., Lenore, S., & Forrester, B. T. (2011). Technology, telehealth, treatment enhancement, and selection. *Professional Psychology: Research and Practice*, 42, 448–454.
- Hatfield, D. R., & Ogles, B. M. (2004). The use of outcome measures by psychologists in clinical practice. *Professional Psychology: Research and Practice*, 35, 485–491.
- Hays, P. A., & Iwamasa, G. Y. (Eds.). (2006). *Culturally responsive cognitive-behavioral therapy*. Washington, DC: American Psychological Association.
- Jameson, J. P., Blank, M. B., & Chambless, D. L. (2009). If we built it, they will come: An empirical investigation of supply and demand in the recruitment of rural psychologists. *Journal of Clinical Psychology*, 65, 723–735.
- Johnson, B. W., & Campbell, C. D. (2004). Character and fitness requirements for professional psychologists: Training directors' perspectives. *Professional Psychology: Research and Practice*, 35, 405–411.
- Jorm, A. F. (2000). Mental health literacy: Public knowledge and beliefs about mental disorders. *The British Journal of Psychiatry*, 177, 396–401.
- Kane, L. (2011). Medscape psychiatry compensation report: 2011 results. Retrieved Dec 27, 2011 from <http://www.medscape.com/features/slideshow/compensation/2011/psychiatry>.
- Kazdin, A. E. (2011). Evidence-based treatment research: Advancements, limitations, and next steps. *American Psychologist*, 66, 685–698.
- Kessler, R. C., Demler, O., Frank, R. G., Olfson, M., Pincus, H. A., et al. (2005). Prevalence and treatment of mental disorders 1990 to 2003. *New England Journal of Medicine*, 352, 2515–2523.
- Kessler, R. C., & Wang, P. S. (2008). The descriptive epidemiology of commonly occurring mental disorders in the United States. *Annual Review of Public Health*, 29, 115–129.
- Kohout, J., & Wicherski, M. (2011). 2011 Graduate Study in Psychology: Applications, acceptances, enrollments, and degrees awarded to master's- and doctoral-level students in the U.S. and Canadian graduate departments of psychology: 2009–2010. *APA Center for Workforce Studies*. Retrieved Dec 21, 2011 from <http://www.apa.org/workforce/publications/11-grad-study/applications.aspx>.
- Korchin, S. J. (1976). *Modern clinical psychology: Principles of intervention in the clinic and community*. New York, NY: Basic Books.
- Korman, M. (Ed.). (1976). *Levels and patterns of professional training in psychology*. Washington, DC: American Psychological Association.
- Kurtzman, H., & Bufka, L. (2011). APA moves forward on developing clinical treatment guidelines. Practice update retrieved December 21, 2011 from <http://www.apapracticentral.org/update/2011/07-14/clinical-treatment.aspx>.
- Lilienfeld, S. O. (2007). Psychological treatments that cause harm. *Perspectives on Psychological Science*, 2, 53–70.
- Michalski, D. (2009). Clinical workforce in psychology: Pipeline, employment, challenges, and opportunities. Presentation given at the American Psychological Association Conference, August 6, Toronto, Ontario, Canada.
- Michalski, D. S., & Kohout, J. L. (2011). The state of the psychology health service provider workforce. *American Psychologist*, 66, 825–843.
- Miller, A. (2013). Phone therapy works for mild to moderate disorders, study suggests. *Monitor on Psychology*, January, 2013, 10.
- National Association of Social Workers website (2012).
- National Center for Education Statistics (2000). Digest of Education Statistics, 1999. Retrieved Dec 13, 2001 from <http://nces.ed.gov/pubs2000/Digest99/d99t298.htm>.
- Nelson, P. D. (2013). Psychology: A science with many applications and a profession with many specialties. Retrieved March 20, 2013 from American Psychological Association Psychology Teacher Network at <http://www.apa.org/ed/precollege/ptn/2013/02/psychology-specialties.aspx>.
- Norcross, J. C. (2011). Clinical versus counseling psychology: What's the diff? Eye on Psi Chi: Fall, 2000 Retrieved Dec 27, 2011 from http://www.psichi.org/pubs/articles/article_73.aspx.
- Norcross, J. C., Beutler, L. E., & Levant, R. F. (2006). *Evidence-based practices in mental health*. Washington, DC: American Psychological Association.
- Norcross, J. C., Ellis, J. L., & Sayette, M. A. (2010). Getting in and getting money: A comparative analysis of admission standards, acceptance rates, and financial assistance across the research-practice continuum in clinical psychology programs. *Training and Education in Professional Psychology*, 42, 99–104.
- Norcross, J. C., Karpiak, C. P., & Santoro, S. O. (2005). Clinical psychologists across the years: The Division of Clinical Psychology from 1960 to 2003. *Journal of Clinical Psychology*, 61, 1467–1483.
- Norcross, J. C., Kohout, J. L., & Wicherski, M. (2005). Graduate study in psychology: 1971 to 2004. *American Psychologist*, 60, 959–975.
- Nordal, K. C. (2010). Where has all the psychotherapy gone? *Monitor on Psychology*, 41, 10.
- Occupational Outlook Handbook, 2010–2011 Edition. U.S. Department of Labor Bureau of Labor Statistics. Retrieved Jan 1, 2012 from <http://www.bls.gov/oco/ocos056.htm>.
- Olos, L., & Hoff, E. H. (2006). Gender ratios in European psychology. *European Psychologist*, 11, 1–11.
- Orchowski, L. M., Spickard, B. A., & McNamara, J. R. (2006). Cinema and the valuing of psychotherapy: Implications for clinical practice. *Professional Psychology: Research and Practice*, 37, 506–514.
- Pate, W. E., II. (2001). Analyses of data from graduate study in psychology: 1999–2000. Retrieved Dec 12, 2001 from APA Research office, <http://research.apa.org/grad00contents.html>.
- Paul, G. L. (1969). Behavior modification research: Design and tactics. In C. M. Franks (Ed.), *Behavior therapy: Appraisal and status* (pp. 29–62). New York: McGraw-Hill.
- Popma, A., & Raine, A. (2006). Will future forensic assessment be neurobiologic? *Child and Adolescent Psychiatric Clinics of North America*, 15, 429–444.
- Prideaux, D., Roberts, C., Eva, K., Centeno, A., Maccrorie, P., et al. (2011). Assessment for selection for the health care professionals and specialty training: Consensus statement and recommendations from the Ottawa 2010 conference. *Medical Teacher*, 33, 215–223.

- Raimy, V. C. (1950). *Training in clinical psychology*. New York NY: Prentice-Hall.
- Rajecki, D. W., & Borden, V. M. H. (2011). Psychology degrees: Employment, wage, and career trajectory consequences. *Perspectives on Psychological Science*, 6, 321–335.
- Rozell, C. A., Berke, D. M., Norcross, J. C., & Karpiak, C. P. (2011). *Clinical psychologists in the 2010s: Fifty-year trends in Division 12 membership*. Presentation given at 2011 American Psychological Association Convention, August 4, 2011, Washington, DC.
- Rozensky, R. H. (2011). The institution of the institutional practice of psychology: Health care reform and psychology's future workforce. *American Psychologist*, 66, 797–808.
- Sales, B. D., Miller, M. O., & Hall, S. R. (2005). Legal credentialing and privileges to practice. In B. D. Sales, M. O. Miller, & S. R. Hall (Eds.), *Laws affecting clinical practice* (pp. 13–22). Washington, DC: American Psychological Association.
- Santoro, S. O., Kister, K. M., Karpiak, C. P., & Norcross, J. C. (2004, April). Clinical psychologists in the 2000s: A national study. Paper presented at the annual meeting of the Eastern Psychological Association, Washington, DC.
- Sayette, M. A., Norcross, J. C., & Dimoff, J. D. (2011). The heterogeneity of clinical psychology Ph.D. programs and the distinctiveness of APCS programs. *Clinical Psychology: Science and Practice*, 18, 4–11.
- Sehgal, R., Saules, K., Young, A., Grey, M. J., Gillem, A. R., Nabors, N. A., et al. (2011). Practicing what we know: Multicultural counseling competence among clinical psychology trainees and experienced multicultural psychologists. *Cultural Diversity and Ethnic Minority Psychology*, 17, 1–10.
- Sharpless, B. A., & Barber, J. P. (2013). Predictors of program performance on the Examination for Professional Practice in Psychology. *Professional Psychology: Research and Practice*, Advance online publication. doi: 10.1037/a0031689.
- Silverman, W. H. (2013). The future of psychotherapy: One editor's perspective. *Psychotherapy*. Advance online publication. doi: 10.1037/a0030573.
- Swaminathan, N. (2012). What predicts grad school success? American Psychological Association gradPSYCH Magazine. Retrieved Mar 20, 2013 from <http://www.apa.org/gradpsych/2012/09/cover-success.aspx>.
- Vasquez, M. J. T. (2011). The internship crisis: Strategies and solutions. *Monitor on Psychology*, 42, 4.
- Weiten, W. (2011). *Psychology: Themes and variations*. New York, NY: Wadsworth/Cengage.
- Wilson, G. T. (2011). Clinical psychology. In P. R. Martin, F. M. Cheung, M. C., Knowles, et al. (Eds.), *IAPP handbook of applied psychology*. Oxford, United Kingdom: Wiley-Blackwell.