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INTRODUCTION TO CLINICAL PSYCHOLOGY

Bridging Science and Practice

NINTH EDITION

INTRODUCTION TO CLINICAL PSYCHOLOGY

Ninth Edition

Thoroughly updated and revised, the ninth edition of this bestselling textbook introduces students to clinical psychology as a bridge between science and practice. Extensive revisions since the previous edition have resulted in the most accessible, up-to-date and thematically integrated edition of *Introduction to Clinical Psychology* yet, while maintaining the authority and accessibility students and instructors have come to rely on.

Updates include:

- Three new co-authors who are internationally recognized scholar-practitioners
- New emphasis on integrating science and practice, illustrating how psychologists use evidence-based practices to help clients
- Addition of the fictional Jackson Family case studies, providing vivid examples of a family confronting numerous mental health challenges
- "Thinking Scientifically" sections in each chapter, which break down how students can think critically when presented with conflicting findings and use the existing evidence to draw the most reasonable conclusions
- "In Review" tables at the end of each major section prompting students to review the material in that section and test their comprehension
- An expanded image program and printed in color for the first time.

Douglas Bernstein is Professor Emeritus at the University of Illinois, and Courtesy Professor of Psychology at the University of South Florida. He founded both the Association for Psychological Science (APS) Preconference Institute on the Teaching of Psychology and the APS Preconference Institute on the Teaching of Psychological Science at the biennial APS International Convention of Psychological Science. He was the founding chairman of the APS Fund for the Teaching and Public Understanding of Psychological Science. He served for 30 years as chairman of the National Institute on the Teaching of Psychology. He has won several teaching awards, including the American Psychological Association (APA) Distinguished Teaching in Psychology Award.

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Scott O. Lilienfeld is Samuel Candler Dobbs Professor of Psychology at Emory University in Atlanta, and Visiting Professor in the School of Psychological Sciences at the University of Melbourne (Australia). His primary areas of interest are personality and personality disorders, individual differences in cognitive bias propensity, evidence-based practice in clinical psychology, psychiatric classification, and applications of scientific thinking to psychology. He is (twice) past-president of the Society for a Science of Clinical Psychology and the recipient of several awards, including the James McKeen Cattell Award for Lifetime Contributions to Applied Psychological Science from the Association for Psychological Science and the Ernst R. Hilgard Award for Lifetime Career Contributions to General Psychology from Division 1 (General Psychology) of the American Psychological Association. He is the author or co-author of over a dozen books, including *50 Great Myths of Popular Psychology* (Wiley) and *Psychology: From Inquiry to Understanding* (Pearson).

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To our mentors, who encouraged us to take the path to clinical psychological science, and to our students, who will lead the way forward.

Contents

Preface

Acknowledgments

Significant Dates and Events in the History of Clinical Psychology

1 What Is Clinical Psychology?

2 Clinical Psychology's Past, Present, and Future

3 Basic Features of Clinical Assessment, Classification, and Diagnosis

4 Interviewing and Observation in Clinical Psychology

5 Testing in Clinical Psychology

6 Basic Features of Clinical Interventions

7 Research on Clinical Intervention

8 Psychoanalytic, Psychodynamic, and Humanistic Psychotherapies

9 Cognitive, Behavioral, and Acceptance-Based Psychotherapies

10 Delivering Mental Health Services

11 Clinical Psychology for Youth and Older Adults

12 Clinical Psychology, Health, and Well-Being

13 Clinical Neuropsychology

14 Forensic Psychology

15 Training and Practice Issues in Clinical Psychology

16 Getting into Graduate School in Clinical Psychology

References
Answer Key
Name Index
Subject Index

Detailed Contents

Preface

Acknowledgments

Significant Dates and Events in the History of Clinical Psychology

1 What Is Clinical Psychology?

- A Clinical Case
- An Overview of Clinical Psychology
  - The Definition of Clinical Psychology
  - The Popularity of Clinical Psychology
  - What Does it Take to Become a Clinical Psychologist?
  - Clinical Psychology and Related Mental Health Professions
  - In Review: An Overview of Clinical Psychology
- Clinical Psychologists at Work
  - What Do Clinical Psychologists Do?
  - Where Do Clinical Psychologists Work?
  - How Much Do Clinical Psychologists Earn?
  - Who Are Clinical Psychologists?
  - Who Are the Clients of Clinical Psychologists?
  - In Review: Clinical Psychologists at Work
- Clinical Psychology in the 21st Century
  - Science and Practice
  - Thinking Scientifically About Evidence
  - Eclecticism and Integration
  - The Health-Care Environment

In Review: Clinical Psychology in the 21st Century
Chapter Summary

2 Clinical Psychology’s Past, Present, and Future
The Roots of Clinical Psychology
The Empirical Tradition
The Psychometric Tradition
The Clinical Tradition
In Review: The Roots of Clinical Psychology
Clinical Psychology Begins to Grow
Psychological Testing Expands
Clinicians Become Psychotherapists
Clinicians Form Professional Organizations
In Review: Clinical Psychology Begins to Grow
Clinical Psychology Branches Out
The Psychodynamic Approach
The Humanistic Approach
The Behavioral Approach
The Cognitive Approach
The Cognitive Behavioral Approach
Social Systems Approaches
The Biological Approach
Comparing Approaches: The Case of Rachel Jackson
In Review: Clinical Psychology Branches Out
Thinking Scientifically: Is it Best to Choose a Single Approach to Clinical Psychology?
Looking ahead
Mechanisms of Change and Transdiagnostic Approaches

The Burden of Mental Illness and the Science–Practice Gap
Mental Hospitals Versus Prisons and Jails
The Changing Landscape of Clinical Practice
New Approaches to Diagnosing Psychological Disorders
Chapter Summary

3 Basic Features of Clinical Assessment, Classification, and Diagnosis
A Clinical Case
An Outline of the Assessment Process
Receiving and Clarifying the Referral Question
Planning Data Collection Procedures
Collecting Assessment Data
Processing Data and Forming Conclusions
Communicating Assessment Results
In Review: An Outline of the Assessment Process
The Goals of Clinical Assessment
Classification and Diagnosis
Description
Planning and Evaluating Treatment
Prediction
Thinking Scientifically: How Good Are Clinicians at Predicting Dangerousness?
In Review: The Goals of Clinical Assessment
Factors Influencing the Choice of Assessment Instruments
Reliability
Validity
Standardization

Bandwidth Versus Fidelity: A Complex Tradeoff

Other Factors Affecting Assessment Choices

In Review: Factors Influencing the Choice of Assessment Instruments

Clinical Judgment and Decision-Making

Clinical Intuition

Improving Clinical Judgment

In Review: Clinical Judgment and Decision-Making

Communicating Assessment Results

Report Clarity

Relevance to Goals

Usefulness of Reports

In Review: Communicating Assessment Results

Ethical Considerations in Assessment

Chapter Summary

4 Interviewing and Observation in Clinical Psychology

Clinical Interview Situations

Intake Interviews

Problem-Referral Interviews

Orientation Interviews

Debriefing and Termination Interviews

Crisis Interviews

Ethnic and Cultural Issues in Clinical Interviews

Thinking Scientifically: Is Psychological Diagnosis Biased?

In Review: Clinical Interview Situations

Interview Structure

Nondirective Interviews

- Semistructured Interviews
- Structured Interviews
- In Review: Interview Structure

Stages in the Interview
- Stage 1: Beginning the Interview
- Stage 2: The Middle of the Interview
- Stage 3: Closing the Interview
- In Review: Stages in the Interview

Evaluating the Quality of Interviews
- Communication and Miscommunication in the Interview
- Reliability and Validity of Interview Data
- In Review: Evaluating the Quality of Interviews

Observational Assessment
- Goals of Observational Assessment
- Limitations of Observational Assessment
- In Review: Observational Assessment

Approaches to Observational Assessment
- Naturalistic Observation
- Controlled Observation
- Behavioral Avoidance Tests
- In Review: Approaches to Observational Assessment

Research on Observational Assessment
- Defining Observational Targets
- Representativeness of Observed Behavior
- Reliability of Observational Assessment
- Validity of Observational Assessment
- In Review: Research on Observational Assessment

Chapter Summary

5 Testing in Clinical Psychology
Basic Concepts in Psychological Testing
What Is a Psychological Test?
How Are Tests Constructed?
Standardization and Score Interpretation
Avoiding Distortion in Test Scores
In Review: Basic Concepts of Psychological Testing
Tests of Intellectual Functioning
Theories of Intelligence
The Binet Scales
The Wechsler Scales
Other Intelligence Tests
Aptitude and Achievement Tests
In Review: Tests of Intellectual Functioning
Thinking Scientifically: Are Intelligence Tests Biased Unfairly Against Certain Groups?
Tests of Attitudes, Interests, Preferences, and Values
Tests of Psychopathology and Personality
Objective Tests of Psychopathology
Objective Tests of Personality
Projective Personality Tests
In Review: Tests of Psychopathology and Personality
The Current Status of Psychological Testing
Reliability and Validity of Psychological Tests
Psychological Testing with Diverse Clients
The Ethical Use of Psychological Tests
New Roles and Goals for Psychological Tests

In Review: The Current Status of Psychological Testing
Chapter Summary

6 Basic Features of Clinical Interventions
Overview of Clinical Interventions
What Is Psychotherapy?
How Many Psychotherapy Approaches Are There?
In Review: Major Approaches to Psychotherapy
The Participants in Psychotherapy
The Client
The Therapist
Thinking Scientifically: Should Psychotherapists Be Required to Have Therapy Themselves?
The Therapeutic Alliance
Settings for Psychotherapy
In Review: The Participants in Psychotherapy
The Goals of Clinical Interventions
Building a Strong Therapeutic Relationship
Fostering Insight
Providing New Information (Education)
Assigning Extratherapy Tasks (Homework)
Developing Faith, Hope, and Expectations for Change
In Review: The Goals of Clinical Interventions
Ethical Guidelines for Clinical Interventions
The APA Ethics Code
Ethics and the Therapist's Values
In Review: Ethical Guidelines for Clinical Interventions
Some Practical Aspects of Clinical Intervention

Treatment Duration and Fees
Record Keeping
Case Formulation and Treatment Planning
Therapist Objectivity and Self-Disclosure
Termination
Two Broad Trends in Clinical Intervention
In Review: Some Practical Aspects of Clinical Intervention
Chapter Summary

7 Research on Clinical Intervention
A Clinical Case
Methods for Studying Psychological Treatments
Basic Designs of Psychotherapy-Outcome Research: Past and Present
In Review: Methods for Studying Psychological Treatments
Results of Research on Individual Treatments
Client Satisfaction Surveys
Box Score Reviews
Meta-Analytic Studies
Thinking Scientifically: Are All Forms of Psychotherapy Equally Effective?
Empirically Supported and Evidence-Based Treatments
Evidence-Based Practice
Research on Common or Nonspecific Factors in Therapy
In Review: Results of Research on Individual Treatments
Results of Research on Other Modes of Intervention
Findings on Group Therapy
Findings on Couples Therapy

Findings on Family Therapy
Findings on Preventive Interventions
Findings on Self-Help Resources and Self-Help Groups
Findings on the Combination of Psychotherapy and Medication
In Review: Results of Research on Other Modes of Intervention
Issues and Concerns about Research on Psychotherapy
Concerns and Compromises in Therapy Research
In Review: Issues and Concerns about Research on Psychotherapy
Chapter Summary

8 Psychoanalytic, Psychodynamic, and Humanistic Psychotherapies
Psychoanalysis
Freud's Theory of Personality and Psychopathology
Foundations of Psychoanalytic Therapy
A Case Example of Psychoanalysis
Thinking Scientifically: Is Freud Dead?
In Review: Psychoanalysis
Psychodynamic Psychotherapy
Adler's Individual Psychology
Jung's Analytical Psychology
Ego Psychology
Object Relations Therapy
Relational Psychodynamic Psychotherapy
Short-Term Psychodynamic Psychotherapy
The Current Status of Psychodynamic Psychotherapy
In Review: Psychodynamic Psychotherapy

Interpersonal Psychotherapy
The Current Status of Interpersonal Psychotherapy
In Review: Interpersonal Psychotherapy
Humanistic Psychotherapy
Person-Centered Therapy
The Goals of Person-Centered Therapy
A Case Example of Person-Centered Therapy
Gestalt Therapy
Existential and Other Humanistic Approaches
The Current Status of Humanistic Psychotherapy
In Review: Humanistic Psychotherapy
Chapter Summary

9 Cognitive, Behavioral, and Acceptance-Based Psychotherapies
Behavior Therapy
Theoretical Foundations
Assessment in Behavior Therapy
Role of the Therapist
Goals of Behavior Therapy
Clinical Applications
Exposure Techniques
A Case Example of Exposure Treatment
Thinking Scientifically: Should EMDR Be a Treatment of Choice for Posttraumatic Stress Disorder?
Social Skills Training
Behavioral Activation and Activity Scheduling
Aversion Therapy and Punishment
A Case Example of Behavior Therapy

In Review: Behavior Therapy
Cognitive Therapy
Theoretical Foundations
Goals of Cognitive Therapy
Cognitive Therapy Methods
In Review: Cognitive Therapy
Cognitive Behavior and Acceptance-Based Therapies
Theoretical Foundations and Extensions
Clinical Applications
Integrating Cognitive Behavior and Acceptance-Based Therapies
The Current Status of Cognitive Behavior and Acceptance-Based Therapies
In Review: Cognitive Behavior and Acceptance-Based Therapies
Chapter Summary

10 Delivering Mental Health Services
Dissemination and Implementation of Clinical Interventions
The Challenges of Dissemination and Implementation
New Models for Delivering Therapy
In Review: Dissemination and Implementation of Clinical Interventions
Group Therapy
Therapeutic Factors in Group Therapy
The Practice of Group Therapy
Cognitive Behavioral Group Therapy
In Review: Group Therapy

Couples and Family Therapy
Diagnosis in Couples and Family Therapy
Couples Therapy Methods
Family Therapy
A Case Example of Family Therapy
The Social Contexts of Couples and Family Therapy
In Review: Couples and Family Therapy
Alternatives to In-Person Therapy by Mental Health Professionals
Technological Innovations
Thinking Scientifically: What are the Effects of Trying to Change Cognitive Biases Using Technology?
Non-Specialist Providers
Prevention Science
Community Psychology
Self-Help
Complementary and Alternative Medicine
In Review: Alternatives to In-Person Therapy with Mental Health Professionals
Chapter Summary

11 Clinical Psychology for Youth and Older Adults
A Brief History of Clinical Child Psychology
In Review: A Brief History of Clinical Child Psychology
Unique Characteristics of Clinical Child Psychology
A Focus on Developmental Stages
Attention to the Contexts of Behavior
Processes for Seeking Help

- Confidentiality
- In Review: Unique Characteristics of Clinical Child Psychology

Clinical Assessment of Children

- Special Considerations in Child Assessment
- Behavior Rating Scales
- Clinical Interviews
- Intelligence and Achievement Tests
- Projective Tests
- Behavioral Observations
- Understanding and Dealing with Inconsistent Assessment Information
- A Case Example
- In Review: Clinical Assessment of Children

Treatment and Prevention of Child and Adolescent Disorders

- Psychosocial Treatments for Disorders in Children and Adolescents
- Pharmacological Interventions

Thinking Scientifically: Do the Risks of Medication for Child and Adolescent Disorders Outweigh Their Benefits?

- A Case Example
- Prevention of Childhood Disorders
- In Review: Treatment and Prevention of Child and Adolescent Disorders

The Future of Clinical Child Psychology

- Diversity and Multiculturalism
- Access to Care
- Interdisciplinary Approaches to Research and Practice

Technology and Youth Mental Health
Clinical Geropsychology
A Brief History of Clinical Geropsychology
The Need for More Geropsychologists
In Review: Clinical Geropsychology
Unique Characteristics of Clinical Geropsychology
Training in Geropsychology
Work Settings for Geropsychologists
A Focus on Life-Span Development
In Review: Unique Characteristics of Clinical Geropsychology
Clinical Assessment with Older Adults
Assessment Methods with Older Adults
A Case Example
In Review: Clinical Assessment with Older Adults
Treatment of Older Adults
Special Considerations in Treating Older Adults
Treatment Methods and Settings
Pharmacological Treatments
A Case Example
In Review: Treatment with Older Adults
The Future of Geropsychology
Diversity and Multiculturalism
Advancing Technology
Chapter Summary

12 Clinical Psychology, Health, and Well-Being
What Is Health Psychology?
Stress, Coping, and Health

Measuring Stressors
Adaptive Coping Strategies
Stress-Hardy Personality Characteristics
Social Support
In Review: What Is Health Psychology?
Risk Factors for Illness
Risk Factors for Cardiovascular Disease
Thinking Scientifically: Does Hostility Increase the Risk of Heart Disease?
In Review: Risk Factors for Illness
Illness Prevention and Treatment Programs
Cardiovascular Diseases
Pain
Cancer
HIV/AIDS
In Review: Illness Prevention and Treatment Programs
Improving Adherence to Medical Treatment
Causes of Nonadherence
Interventions to Improve Adherence
In Review: Improving Adherence to Medical Treatment
A Case Example of Health Psychology
Chapter Summary

13 Clinical Neuropsychology
A Clinical Case
A Brief History of Neuropsychology
Early Influences
Development of Neuropsychological Assessment Techniques

- Split-Brain Research
- Research on Normal Brains
- In Review: A Brief History of Neuropsychology

Basic Principles of Neuropsychology
- A Modern View of Localization of Function
- Modules and Networks
- Levels of Interaction
- Lateralization of Function

Thinking Scientifically: Can Someone Be Partially Paralyzed and Really Not Know It?
- In Review: Basic Principles of Neuropsychology

Patterns of Neuropsychological Dysfunction
- Occipital Lobe Dysfunction
- Parietal Lobe Dysfunction
- Temporal Lobe Dysfunction
- Frontal Lobe Dysfunction
- Neuropsychological Syndromes
- In Review: Patterns of Neuropsychological Dysfunction

Neuropsychological Assessment
- Neuropsychological Test Batteries
- Individualized Approaches to Neuropsychological Testing
- Neuropsychological Assessment and Rehabilitation
- In Review: Neuropsychological Assessment

Neuropsychological Approaches to Psychopathology
- Depression
- Schizophrenia
- Developmental Disorders

In Review: Neuropsychological Approaches to Psychopathology
The Current Status of Clinical Neuropsychology
Chapter Summary

14 Forensic Psychology
The Scope of Forensic Psychology
In Review: The Scope of Forensic Psychology
Criminal Competence and Responsibility
Criminal Competence
Assessing Competence
The Insanity Defense
Assessing Sanity
Thinking Scientifically: Does the Insanity Defense Allow Killers to Get Away with Murder?
Reforming the Insanity Defense
In Review: Criminal Competence and Responsibility
Assessing Psychological Status in Civil Cases
Assessing Psychological Damage in Tort Cases
Workers' Compensation Cases
Civil Competencies
In Review: Assessing Psychological Status in Civil Cases
Psychological Autopsies and Criminal Profiling
Psychological Autopsies
Criminal Profiling
In Review: Psychological Autopsies and Criminal Profiling
Child Custody and Parental Fitness
Child Custody Disputes

Custody Mediation
Termination of Parental Rights
In Review: Child Custody and Parental Fitness
Mental Health Experts in the Legal System
In Review: Mental Health Experts in the Legal System
Chapter Summary

15 Training and Practice Issues in Clinical Psychology
Professional Training
The Boulder Conference
The Vail Conference
The Salt Lake City Conference
The Delaware Conference
Clinical Psychology Training Today
Professional Schools and the Doctor of Psychology (Psy.D.) Degree
Clinical Psychology Training Models
Evaluating Clinical Psychology Training
The Internship Imbalance
In Review: Professional Training
Professional Regulation
Certification and Licensure
ABPP Certification
In Review: Professional Regulation
Professional Ethics
Ethical Standards of the American Psychological Association
Implementation of Ethical Standards
Dealing with Ethical Violations

Other Ethical Standards
Regulation Through State Laws
Regulation Through Malpractice Litigation
In Review: Professional Ethics
Professional Independence
The Economics of Mental Health Care
Independent Practice
Prescription Privileges
In Review: Professional Independence
Professional Multicultural Competence
Thinking Scientifically: Does Cultural Competence Improve Therapy Outcomes?
A Case Study of Culturally Competent Therapy
In Review: Professional Multicultural Competence
The Future of Clinical Psychology
Training
Psychotherapy Integration
Interdisciplinary Science and Practice
Positive Psychology
Spirituality
Technology
Dissemination
Outreach to the National and International Communities
A Final Word
In Review: The Future of Clinical Psychology
Chapter Summary

16 Getting into Graduate School in Clinical Psychology

What Types of Graduate Programs Will Help Me Meet My Career Goals?

- Research Versus Clinical Emphasis?
- M.A., Ph.D., or Psy.D.?

Am I Ready to Make the Commitment Required by Graduate Programs at This Time in My Life?

- Time Commitments
- Financial Commitments
- Academic and Emotional Commitments

Are My Credentials Strong Enough For Graduate School in Clinical Psychology?

- Undergraduate Coursework and Experience
- Graduate Record Exam Scores
- Grade Point Average
- Letters of Recommendation
- Given My Credentials, to What Type of Program Can I Realistically Aspire?

I Have Decided to Apply to Graduate School in Clinical Psychology. What Should I Do Now?

- How Do I Get Information About Graduate Programs and Identify “Good” Ones?
- What Does It Mean When a Clinical Psychology Graduate Program is Accredited by the American Psychological Association?
- What Does it Mean When a Clinical Psychology Graduate Program is Accredited by the Psychological Clinical Science Accreditation System?
- When Should I Apply, and What Kind of Timeline Should I Expect?

To How Many Programs Should I Apply?
How Much Will It Cost to Apply?
What Testing is Involved in Applying to Graduate School?
What is the GRE?
Should I Study for the GRE?
How Important is My Grade Point Average?
Will I Need Letters of Recommendation? If so, How Many and from Whom?
What Should I Know About Asking for Letters of Recommendation?
Will I Be Able to See My Letters of Recommendation?
What Should I Include in My Personal Statement?
Are Personal Interviews Required?
How Do I Prepare for an Onsite Interview?
What Kind of Financial Aid Is Available for Graduate Study?
When I Am Admitted to a Program, How Long Will I Have to Make a Decision About Whether to Accept?
Will I Be Successful in Gaining Admission?
What Are your Rights as a Graduate Student?
Chapter Summary

References
Answer Key
Name Index
Subject Index

Preface

The eight previous editions of this book have all shared the same four goals. The first is to offer an introduction to clinical psychology that, while appropriate for graduate students, is written especially with intellectually curious undergraduates in mind. Many psychology majors have an interest in clinical psychology, but not a clear understanding of what the field involves and requires. Many nonmajors, too, want to know more about clinical psychology, and we believe that both groups can benefit from a thorough survey of the field that does not delve into all the details typically included in texts aimed only at graduate students. Readers whose backgrounds include coursework in introductory psychology and abnormal psychology will find the book especially valuable.

The second goal is to present the whole story of clinical psychology, its history, its present scope and functions, and a glimpse into its future. We do so in a way that includes the perspectives of many approaches to clinical psychology—the behavioral, interpersonal, cognitive behavioral, humanistic, psychodynamic, acceptance-based, social systems, etc.— and that highlights the strengths and weaknesses of the scientific evidence for each.

The third goal is to emphasize the value of scientific research in clinical psychology. We believe this is a necessary and useful perspective for all clinical psychologists, whether they are practitioners, researchers, educators,

policy makers, or consultants. So you will see as a core theme throughout the book the idea that an evidence-based approach to clinical psychology offers the best hope for helping clients because it is the one most likely to identify the causes of, and effective treatments for, psychological disorders.

The fourth goal is to offer a book that is interesting and enjoyable. As you might expect, we love the field of clinical psychology. We find it fascinating. We enjoy teaching about it and writing about it, and we hope that some of our excitement and enthusiasm will rub off on you.

These four goals have not changed, but many other aspects of the book are new. First and foremost, the ninth edition benefits from the knowledge, skills, and experience of three new members of the author team. Led by Doug Bernstein of the University of South Florida, who co-wrote the first edition in 1980, the team now includes Bethany Teachman of the University of Virginia, Bunmi Olatunji of Vanderbilt University, and Scott Lilienfeld of Emory University. Here is what we have done for the ninth edition:

1. Content Updates. We have added more than 1000 new references that describe the latest scientific research and information about all aspects of contemporary clinical psychology. We cover the development of evidence-based clinical science, emerging models for clinical training and accreditation, new approaches to diagnosing and classifying the key features of mental illness, and the latest trends in formulating and evaluating interventions for the treatment of those disorders. We also summarize the latest changes in health-care legislation and managed-care systems, and advances in the delivery of mental health-care services (imagine treatment through a smartphone app!) that will influence clinical psychology training, research, and practice.

The structure and sequence of some chapters have also changed. In

particular, the Clinical Child Psychology chapter has been expanded to include a major section on Clinical Geropsychology, and renamed Clinical Psychology for Youth and Older Adults. In addition, the chapter on Research on Clinical Intervention now appears before, rather than after, the chapters on specific types of treatment. This change reflects our desire to emphasize that clinicians of all theoretical persuasions should use scientific methods to evaluate the effectiveness of clinical interventions.

2. More Integrated Case Examples. In this new edition, we wanted to provide more examples of the kinds of clients and client problems that clinical psychologists encounter in their research and practice. We also wanted to show you how the same clients and problems can be understood from many different theoretical perspectives. So, in Chapter 1 we introduce you to the members of the "Jackson" family (not their real name), who illustrate many of the fascinating problems and practice issues that clinical psychologists encounter every day. Our description of each family member will provide vivid and easily grasped examples of clinical assessment techniques, therapeutic methods, symptoms of psychological disorders, the importance of sociocultural factors in diagnosis and treatment, and the like. As you read the book, you will meet the same family members in varying combinations (e.g., in family therapy sessions) and in different contexts (e.g., diagnostic interviewing, neuropsychological assessment, individual therapy), rather than always being introduced to entirely new cases. By providing background information about a single family, its history, and its dynamics in Chapter 1, many of the case examples in later chapters will involve people with whom you will already be familiar.

3. Scientific Thinking about Current Controversies. Clinical psychology is an ever-changing field, and proposals for change often meet with varying

reactions. As a result, there are a number of topics about which clinical psychologists and other mental health professionals disagree, such as how much weight should be given to various sources of evidence when making clinical decisions, how clinical psychologists should be trained, and whether they should be allowed to prescribe medication for psychological disorders. We describe these and many other current controversies throughout the book, and in special sections in every chapter we invite you to "Think Scientifically" about them by asking yourself five specific questions:

What am I being asked to believe?

What kind of evidence is available to support the claim?

Are there alternative ways of interpreting the evidence, including those that my biases and preconceptions might have kept me from seeing?

What additional evidence would help to evaluate those alternatives?

What conclusions are most reasonable given the kind of evidence available?

4. Additional Coverage of Clinical Technology. Updating the book gave us the opportunity to describe the changes taking place in clinical psychology that involve new digital technologies. You will see examples of these changes throughout the book that relate to everything from delivery of mental health services via the internet and social media, to the use of artificial intelligence in clinical assessment, and the application of virtual reality systems in various kinds of treatment.

5. Highlighting Individual Differences and Sociocultural Diversity. The sociocultural characteristics of clinical psychologists and their clients have

become increasingly diverse over the years. As a result, you will find that our coverage of everything from clinical training and assessment techniques to treatment methods and health-care delivery systems takes into account the impact of factors such as age, gender, race and ethnicity, culture and nationality, sexual orientation, and disability status on clinical research and practice.

6. More Reader-Friendly Features. We have added a number of new elements to the ninth edition that are designed specifically to make the book easier and more enjoyable to read, more supportive of your learning, and more helpful when the time comes to study for quizzes and tests.

- First, we have used a larger font, which makes for less tiring reading, and we added more than 20 new photos, figures, and tables to illustrate the text and add variety to your reading experience.
- Second, all the most important key terms are now printed in **boldface** type and are reproduced, along with their definitions, in the margin after the first mention of each term.
- Third, we have retained the chapter and section previews that help you to anticipate what you are about to read, but we have also added “In Review” tables at the end of each major section of every chapter. These tables summarize the main points of the section and then pose three self-testing questions that give you a chance to see if you have understood the material in the section or if you might want to go back and re-read some of it (the answers to the self-test questions are at the back of the book).

We hope you enjoy reading the ninth edition as much as we enjoyed creating it. We would love to hear your comments and suggestions for further improvement, so please feel free to contact the author team through Doug Bernstein at douglas.bernstein@comcast.net.

Here we are, from left to right: Bunmi Olatunji, Scott Lilienfeld, Bethany Teachman, and Doug Bernstein during our two-day planning session for the new edition in Atlanta in 2018.

Acknowledgments

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Significant Dates and Events in the History of Clinical Psychology

1879

Wilhelm Wundt establishes first formal psychology laboratory at the University of Leipzig.

1885

Sir Francis Galton establishes first mental testing center at the South Kensington Museum, London.

1890

James McKeen Cattell coins the term *mental test*.

1892

American Psychological Association (APA) founded.

1895

Breuer and Freud publish *Studies in Hysteria*.

1896

Lightner Witmer founds first psychological clinic, University of Pennsylvania.

1905

Binet–Simon Intelligence Scale published in France.

1907

Witmer founds first clinical journal, *The Psychological Clinic*.

1908

First clinical internship offered at Vineland Training School.

1909

William Healy founds first child guidance center, the Juvenile Psychopathic Institute, Chicago.

Freud lectures at Clark University.

1910

Goddard's English translation of the 1908 revision of the Binet–Simon Intelligence Scale published.

1912

J.B. Watson publishes *Psychology as a Behaviorist Views It*.

1916

Terman's Stanford–Binet Intelligence Test published.

1917

Clinicians break away from APA to form American Association of Clinical Psychology (AACP).

1919

AACP rejoins APA as its clinical section.

1920

Watson and Rayner demonstrate that a child's fear can be learned.

1921

James McKeen Cattell forms Psychological Corporation.

1924

Mary Cover Jones employs learning principles to remove children's fears.

1931

Clinical section of APA appoints committee on training standards.

1935

Thematic Apperception Test (TAT) published.

1937

Clinical section of APA breaks away to form American Association for Applied Psychology (AAAP).

1938

First Buros *Mental Measurement Yearbook* published.

1939

Wechsler–Bellevue Intelligence Test published.

1942

Carl Rogers publishes *Counseling and Psychotherapy*, outlining an alternative to psychodynamic therapy.

1943

Minnesota Multiphasic Personality Inventory (MMPI) published.

1945

AAAP rejoins APA.

Journal of Clinical Psychology published.

Connecticut State Board of Examiners in Psychology issues first certificate to practice psychology.

1947

American Board of Examiners in Professional Psychology organized.

Shakow Report recommends clinical training standards to APA.

1949

Colorado conference on training in clinical psychology convenes, recommends “Boulder Model.”

1950

APA publishes first standards for approved internships in clinical psychology.

1952

American Psychiatric Association’s *Diagnostic and Statistical Manual (DSM-I)* published.

1953

APA’s *Ethical Standards for Psychologists* published.

1955

Wechsler Adult Intelligence Test published.

1956

Stanford Training Conference.

1958

Miami Training Conference.

Clinical Division of APA holds National Institute of Mental Health sponsored conference about research on psychotherapy.

1959

The first psychotherapy benefit in a prepaid insurance plan appears.

1965

Chicago Training Conference held.

1968

Psy.D. training program begins at the University of Illinois, Urbana-Champaign.

Second edition of *Diagnostic and Statistical Manual* (*DSM-II*) published.

Committee on Health Insurance begins campaign to allow payment of clinical psychologists’ services by health insurance plans without requiring medical supervision.

1969

California School of Professional Psychology founded.

APA begins publication of the journal, *Professional Psychology*.

1970

Department of Defense health insurance program authorizes payment of clinical psychologists’ services without medical referral.

1971

Council for the Advancement of Psychological Professions and Sciences, a political advocacy group for clinical psychology, is organized.

Journal of Clinical Child Psychology published.

1972

Menninger Conference on Postdoctoral Education in Clinical Psychology.

1973

Vail, Colorado, Training Conference.

1974

National Register of Health Service Providers in Psychology established.

Federal government allows payment for clinical psychologists’ services to its employees without medical supervision or referral.

APA establishes *Standards for Providers of Psychological Services*.

First Inter-American Congress of Clinical Psychology held in Porto Alegre, Brazil.

1977

All 50 U.S. states have certification or licensing laws for clinical psychologists.

1980

Third edition of *DSM* (*DSM-III*) published.

Smith, Glass, and Miller publish *The Benefits of Psychotherapy*.

Blue Shield health insurance companies in Virginia successfully sued for refusing to pay for clinical psychologists' services to people covered by their plans.

1981

APA publishes its revised *Ethical Principles of Psychologists*.

1983

Joint Commission for the Accreditation of Hospitals allows clinical psychologists to become members of hospital medical staff.

Conference on graduate education in psychology, Salt Lake City, Utah.

1988

American Psychological Society formed.

1990

California Supreme Court affirms right of clinical psychologists to independently admit, diagnose, treat, and release mental patients without medical supervision.

Dick McFall publishes “Manifesto for a Science of Clinical Psychology.”

1993

Commander John L. Sexton and Lt. Commander Morgan T. Sammons complete psychopharmacology program at Walter Reed Army Medical Center, becoming first psychologists legally permitted to prescribe psychoactive drugs.

1994

DSM-IV published.

Amendment to Social Security Act guarantees psychologists the right to independent practice and payment for hospital services under Medicare.

Academy of Psychological Clinical Science established.

1995

APA task force of clinical psychologists publishes list of empirically validated psychological therapies and calls for students to be trained to use them.

1996

Dorothy W. Cantor becomes first president of APA to hold a Psy.D. rather than a Ph.D..

2002

New Mexico grants prescription privileges to specially trained clinical psychologists.

2005

APA sponsors a Presidential Task Force on evidence-based practice.

2006

Psychologists win a second settlement in 2 years in federal court alleging that managed-care companies conspired to reduce and delay provider payments in violation of federal law.

American Psychological Society becomes The Association for Psychological Science.

2008

The U.S. House of Representatives passes legislation requiring mental health parity: The Paul Wellstone Mental Health and Addiction Equity Act of 2007.

2009

University of Illinois at Urbana-Champaign becomes the first Psychological Clinical Science Accreditation System-accredited program.

1

What Is Clinical Psychology?

◈

Contents

An Overview of Clinical Psychology
Clinical Psychologists at Work
Clinical Psychology in the 21st Century

Chapter Preview

Clinical psychology is one of the most important and fascinating areas of psychology, and we have the pleasure of introducing it to you in the pages of this book. Our opening chapter provides a broad overview of the field. We'll describe what clinical psychology is, what clinical psychologists do, where they work, how they are trained, and how clinical psychology is related to other domains of psychology, including other mental health fields. Whether you have only a casual interest in the field or you are thinking about becoming a clinical psychologist yourself, this chapter's overview will set the stage for the others that focus on more specific topics.

A Clinical Case

Let's start our exploration of clinical psychology with an example of the kinds of people and problems that clinical psychologists encounter every day. "Rachel Jackson" (not her real name) is a 17-year-old student at a suburban high school in the midwestern United States. She has always been a bit on the rebellious side, but at the beginning of her junior year, she started hanging out with a new group of friends who routinely smoke marijuana, drink alcohol, skip classes, and encourage her to do the same. Like them, she has come to think of schoolwork as pointless, so her grades—which were only average to begin with—have been suffering. Rachel's tendency to be slightly overweight had never been of great concern to her until

recently when a few snide remarks by some of her new friends prompted her to go on a crash diet.

Because of his own problems, Rachel's father James, a 45-year-old African American accountant, has not been paying much attention to his daughter's behavior, or that of his two younger children, 12-year-old fraternal twins Jamal and Janelle. James' withdrawal began shortly after he lost his job during a downturn in the local economy, leaving his wife Lena's salary as a nurse as the family's only source of income. He has bouts of depression, sleeps poorly, complains about the house being "a mess," and constantly worries about money, despite spending far too much time and cash at a local bar. But Lena, the 43-year-old daughter of Lithuanian immigrants, has recognized that Rachel could be heading for trouble. Lena is estranged from her older sister, Regina, and has no close friends in her mainly European American neighborhood that has not exactly welcomed her mixed-race family (Lena is white). Lena finally decided to share her concerns about her daughter with "Ellen Yang" (not her real name), a friend and fellow nurse at her hospital. On Ellen's advice, Lena contacted a guidance counselor at Rachel's school. The counselor felt that the situation deserved the attention of a mental health professional, and she referred Lena to "Dr. Cynthia Leon," a clinical psychologist at a nearby community mental health center.

At their first appointment, Lena describes some of Rachel's problems, but soon finds herself talking about other concerns, too, including her husband's emotional disengagement, her worries about its impact on her marriage and the children, her aging mother's declining physical health and loss of mental capacity, and her own

feelings of sadness, low energy, and hopelessness about what sometimes seems to be an impossibly stressful living situation. The clinical psychologist listens carefully, and among other things, points out that while Rachel's behavior is certainly a focus of concern, it seems to be only one feature of an enormously complex and dynamic family system.

That first appointment marked the beginning of the psychologist's efforts to help Rachel, and ultimately, her entire family. You will discover more about the Jackson family in many of the chapters to come, where we present their stories as examples of how clinical psychologists use scientific approaches to describe, understand, and resolve the problems of the individuals, couples, and families who come to them for help.

In this book, you will see how clinical psychologists address problems such as those faced by Rachel and her family. You will learn how they assess and treat people with psychological problems, how they conduct research on the measurement, causes, treatment, and prevention of those problems, and how clinicians are trained. You will also 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. Finally, you will learn about the ongoing challenges and controversies confronting the field of clinical psychology, including those bearing on the diagnoses of mental disorders, and the effectiveness of psychotherapy.

An Overview of Clinical Psychology

Section Preview In this section, we define clinical psychology and identify the requirements for entering the field. We also discuss the continued appeal of clinical psychology as a profession, popular conceptions and misconceptions of clinical psychologists, and how clinical psychology overlaps with, and differs from, other mental health professions.

The Definition of Clinical Psychology

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.* They conduct research about human behavior, seek to apply the results of that research, and engage in the assessment of clients. Like the members of some other professions, clinical psychologists also provide assistance to those who need help with psychological problems, but as you will soon see, they also serve as educators and administrators and help shape policies about health care and the application of psychological science to solve human problems. It is difficult to capture in a sentence or two the ever-expanding scope and new directions of clinical psychology today, but we can outline its central features.

On its website at www.div12.org, the American Psychological Association Division of Clinical Psychology defines **clinical psychology** as the field of psychology that "involves research, teaching and services relevant to the applications of principles, methods, and procedures for understanding, predicting, and alleviating intellectual, emotional, biological, psychological, social and behavioral maladjustment, disability and discomfort, applied to a wide range of client populations." Notice that this definition focuses on the *integration* of clinical science and clinical practice, the *application* of this integrated knowledge across diverse human populations, and the *purpose* of alleviating human suffering and promoting health. The definition also highlights a crucial point that we'll be emphasizing throughout this book, namely that clinical science and clinical practice are not and should not be

separate, but instead are flip sides of the same coin. To be a responsible and competent clinical psychologist, one must learn to evaluate and integrate the best available scientific evidence that bears on assessing, treating, understanding, and preventing mental health problems. And to be a good researcher, it is critical to understand how mental health problems actually present themselves and how they are managed in the real world.

Clinical psychology

The field of psychology that involves research, teaching, and services relevant to the application of principles, methods, and procedures for understanding, predicting, and alleviating cognitive, emotional, biological, social and behavioral maladjustment, impairment, distress, and discomfort, applied to a wide range of client populations.

The Popularity of Clinical Psychology

Clinical psychology is the single largest subfield of psychology. Its prominence is reflected in the fact that just over 40% of the nearly 75,000 members of the American Psychological Association (APA) identify themselves as clinical psychologists and constitute the three largest of the 56 interest groups (divisions) in the APA: Clinical Psychology (Division 12), Clinical Neuropsychology (Division 40), and Psychologists in Independent Practice (Division 42). Graduate training programs in clinical psychology are the most popular of psychology's *health service provider (HSP)* training options (American Psychological Association, 2016a, 2019a), attracting more applicants each year than any other area (American Psychological Association, 2018a; Michalski, Cope & Fowler, 2016; see Figure 1.1). It is no surprise, then, that almost one-half of all psychology doctorates are awarded in clinical psychology (American Psychological Association, 2016a). Part of the attraction lies in the prospect of high-quality, satisfying employment for clinical psychologists (Lin, Christidis, & Stamm, 2017). The U.S. Department of Labor's *Occupational Outlook Handbook* projects faster-than-average growth in the job market for both doctoral- and master's-level clinicians (Bureau of Labor Statistics, 2018). Many of those drawn to clinical psychology are also fascinated by the mysteries of mental disorders and the desire to help others in distress.

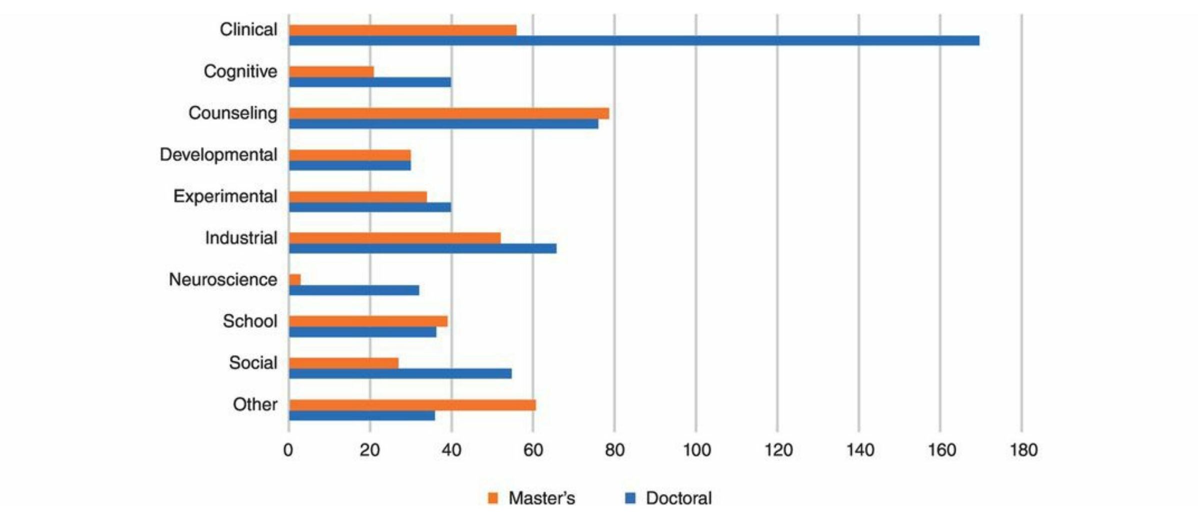


Figure 1.1 Average Number of Applications for Graduate Training in Psychology
The average psychology department in the United States receives far more applications for doctoral training in clinical psychology than for any other subfield. This has created intense competition for admission to clinical programs. Only about 13% of doctoral applicants and about 35% of master's applicants are admitted to these programs.

(Source: Adapted from Michalski, D. S., Cope, C., & Fowler, G. A. (2016). *Summary report: Admissions, applications, and acceptances.* Washington, DC: American Psychological Association Education Directorate.)

Though most people tend to think of *all* psychologists as clinicians, that is not the case. As shown in Figure 1.1, psychology has many other subfields, but the false impression is strengthened, for better or worse, by portrayals of psychologists in movies, on television, and in other media. Virtually all of them are of clinical psychologists. The more accurate portrayals contribute to *mental health literacy*—the public's understanding of psychological disorders and their treatment (Altweck et al., 2015)—but the rest tend to decrease

mental health literacy by creating inaccurate, stereotyped views of the field, and even discouraging troubled people from seeking treatment. Unfortunately, the second kind is far more common (Jamieson, 2011; Vogel, Gentile, & Kaplan, 2008). Clinical psychologists are too often portrayed as all-knowing oracles or dramatically wounded healers who use techniques that do not reflect the way today's clinical scientists practice (Orchowski, Spickard, & McNamara, 2006). In many cases, the media imply, or even state, that clinical psychology and psychiatry are the same (Lilienfeld, 2012) when, as you will see later in this chapter, they are not. Such portrayals help create the misconceptions reflected in surveys showing that most people don't understand the differences between clinical psychologists, psychiatrists, and other mental health professionals such as social workers and counselors (Farberman, 1997). These shows may enjoy good audience ratings, but they rarely present a true picture of the science and practice of modern clinical psychology. We hope that by reading this book you will gain a much more accurate impression of the field.

What Does it Take to Become a Clinical Psychologist?

One of clinical psychologists' most distinctive characteristics has been called the **clinical attitude** or the *clinical approach* (Korchin, 1976). This orientation reflects a desire to combine knowledge from research on human behavior and mental processes *in general* with efforts at *individual* assessment and treatment in order to understand and help a given person. The clinical attitude sets clinicians apart from other psychologists who search for underlying principles that can be applied to human behavior problems in general. Clinical psychologists like the one who met with Rachel's mother, Lena, are interested in research of this kind, but they also want to know how those general principles shape lives, problems, and treatments on an individual level.

Clinical attitude
The desire to combine research knowledge with individual assessment and treatment.

It is vital that clinical psychologists embrace a **scientific attitude** as well, meaning that they apply scientific approaches to understanding psychological distress (McFall, 1991; O'Donohue & Lilienfeld, 2007). We believe that the most effective clinical psychologists are those who help others by using the best available evidence drawn from carefully conducted scientific studies.

Scientific attitude
The desire to apply scientific approaches to understanding psychological distress.

Personal Characteristics. Because clinical psychology at its best is both rigorously scientific and deeply personal, it requires that people entering the field have a strong and compassionate interest in human beings. The committees in charge of admitting students for graduate study in clinical psychology look for applicants who are not only smart, but who have integrity, an interest in people, good interpersonal communication skills, empathy, and intellectual curiosity (Johnson & Campbell, 2004; Prideaux et al., 2011; Swaminathan, 2012). These traits are important in many jobs, of course, but they are especially crucial in clinical psychology because clinicians regularly work in situations that can have significant and lasting personal and interpersonal consequences. The same traits are important even for clinical researchers who don't themselves offer psychotherapy because they may still make decisions about matters of personal consequence to research participants.

The potential impact that clinical psychologists can have on individuals' lives helps explain why a clinical training applicant's letters of recommendations, personal statements, and interviews may be given slightly more weight by admissions committees than standardized academic indicators such as grade point averages (GPAs) or Graduate Record Exam (GRE) scores (Littleford et al., 2018; Michalski, Cope & Fowler, 2016).

Nevertheless, as you will see in Chapter 16, on Getting into Graduate School in Clinical Psychology, those standardized academic indicators must still be quite high, partly because they have some value for predicting success in graduate school and scores on the national licensing tests we describe later (Sharpless & Barber, 2009).

Another key characteristic of clinical psychologists is a propensity toward scientific thinking (Garb, 1998). It is a way of thinking that provides tools that help compensate for personal biases that might otherwise impair a clinical scientist's search for the truth about a client's problems or a knotty research question (Lilienfeld, 2010). Scientific thinking doesn't come naturally, partly because it is more difficult than unscientific thinking, but it can be developed through extensive training, concerted effort, and guided experience. Competent clinical psychologists apply their scientific thinking skills in research, of course, but also in their approach to clinical work. Their scientific mindset leads them to interpret research evidence thoughtfully, apply research to clinical practice appropriately, and always remain open to the possibility that their conclusions and decisions might be mistaken and require adjustment (McFall, 1991, 1996). Because prior research experience helps to develop a scientific mindset, it is often a requirement for admission to clinical doctoral programs.

Legal Requirements. Clinical psychologists who offer services such as the assessment and treatment of psychological disorders must be licensed or certified by state and national agencies. In the United States and Canada, each state or province establishes the requirements for licensure, awards licenses to those who qualify, and has the power to limit 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 clinicians to practice independently; that is, to “hang out a shingle.” This means that fully licensed practitioners can set up their own offices, set their own fees and working hours, submit bills to insurance companies or other third parties, offer consultation services, testify in court, and engage in a number of other activities characteristic of independent private practice. In many states, those without a full license are subject to some of the practice limitations we describe in the next section.

Educational and Ethical Requirements. The minimum educational requirement for full licensure in clinical psychology is usually a doctoral degree earned through a regionally accredited or government-chartered institution’s clinical training program (Dittmann, 2018). Students in these programs complete substantial advanced coursework in psychopathology (mental illness), assessment, and intervention strategies, gain exposure to a wide variety of basic research in psychological science (e.g., cognitive and developmental psychology), learn skills in statistical analyses, and conduct varying amounts of clinical research.

Graduate students in clinical psychology must also learn to understand and follow the *ethical standards* that govern the work they do both before and after graduation. These standards are spelled out in the American Psychological Association’s *Ethical Principles of Psychologists and Code of Conduct* (2017a), which offers guidance for dealing with ethical concerns related to competence, human relations, privacy and confidentiality, record keeping, education and training, therapy, and many other situations. This code is especially useful in navigating some of the ethical “gray areas” that invariably arise in the practice of clinical psychology.

Clinicians in Training

Because they will so often deal with people who are distressed and vulnerable, students wishing to become clinical psychologists must display the personal characteristics—and satisfy the rigorous educational and legal requirements—that are associated with the highest standards of competence and ethical behavior.

(Source: Klaus Vedfelt/DigitalVision/Getty Images.)

The ethical code also applies to graduates of clinical psychology training programs who choose not to seek licensure or offer direct clinical service to the public. These clinical psychologists are typically involved in some combination of teaching, research, consulting, or administration—often as faculty members in college or university psychology departments. For them, some of the most relevant ethical standards in the code are the ones dealing with faculty–student relationships, teaching quality, and research practices. Their research is also overseen by *Institutional Review Boards* (known in some countries as ethics boards), which operate within their college or

university under government guidelines designed to protect the rights and well-being of the human or animal participants being studied.

The doctoral degrees held by fully licensed clinical psychologists are typically either the *Ph.D.* (Doctor of Philosophy) or the *Psy.D. (Doctor of Psychology)*, though they occasionally include others, such as the *Ed.D.*, or Doctor of Education. Both Ph.D. and Psy.D. programs include intensive clinical training, but they differ in their emphasis on science and research. Later in this chapter, and in subsequent ones, we will describe the differences between these two training models and summarize ongoing debates about their advantages and disadvantages. For now, just be aware that Psy.D. programs are less research-intensive and that they accept and graduate far more doctoral-level clinical psychologists than Ph.D. programs do (American Psychological Association, 2016a, 2018b; Norcross, Ellis, & Sayette, 2010; Sayette, Norcross, & Dimoff, 2011).

At the sub-doctoral level, clinical practitioners have titles such as *limited license psychologist*, *marriage and family therapist*, *psychological assistant*, *behavioral* or *mental health counselor*, and the like (Campbell et al., 2018). Obtaining a limited license usually requires a master's degree in psychology. Some states regulate the limited license much as they do with full licenses, but others provide less oversight, or no oversight, for sub-doctoral practitioners (Sales, Miller, & Hall, 2005). Because they do not hold a full license, master's-level clinicians may be required to practice under the supervision of a fully licensed psychologist. They may also receive less reimbursement for their services from insurance companies, lower salaries, and less employment stability (Rajecki & Borden, 2011). This is not to say that well-trained and qualified master's-level clinicians provide inferior services, but rather that, as in medicine, law, and other professions, higher

levels of training are usually associated with more advanced or specialized skills and greater financial rewards.

Experience. Most states require that candidates for licensure obtain a certain amount of supervised clinical experience both before and after completion of their doctoral degrees. Even after being licensed, clinicians in all U.S. states, except New York, are required to take continuing education courses as part of a periodic license renewal process.

Supervised clinical experience typically includes the successful completion of an approved practicum, a one-year full-time (or two-year half-time) clinical internship in a practice setting (such as a psychiatric hospital), or some other period of extensive supervision. Practicum courses are usually part of the clinician's predoctoral training and often involve conducting clinical assessment and/or treatment sessions at a psychology department clinic under the supervision of a clinical faculty member or at an external site, such as a local psychiatric hospital or university counseling center. Internships involve one to two years of much more extensive clinical work for which interns are typically paid a modest stipend. For lists of the clinical psychology doctoral programs and internships approved by the American Psychological Association, visit http://www.apa.org/ed/accreditation/programs/index.aspx and http://www.apa.org/education/grad/internship.aspx. A list of programs with a particularly strong focus on clinical science is provided at the website of the Academy of Psychological Clinical Science at https://www.acadpsychclinicalscience.org/doctoral-programs.html.

Competence Testing. To be licensed as clinical psychologists, candidates must declare their areas of competence to licensing boards and 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 U.S. 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, through a process called *reciprocity*. Some states require other examinations, particularly if candidates want to declare certain areas of competency, such as clinical neuropsychology or health psychology, and some require additional tests in ethics. Clinicians are also discussing the possibility of adding a second EPPP test that is focused more on demonstrating competencies in clinical skills than on displaying academic knowledge.

Clinical Psychology and Related Mental Health Professions

As we mentioned earlier, clinical psychology is designated by the U.S. government as a *health service provider subfield*, but it is not the only one in psychology. Psychologists also provide services in subfields such as counseling psychology, school psychology, behavior analysis, family psychology, rehabilitation psychology, and sport psychology. As we describe in later chapters, still other psychologists provide specialized services to children, adolescents, or the elderly (Chapter 11), work to promote health and well-being (Chapter 12), and practice clinical neuropsychology (Chapter 13) or forensic psychology (Chapter 14). Clinical services are also offered by professionals trained outside psychology in professions such as social work, psychiatry, addiction counseling, marital and family counseling, and psychiatric nursing. Like clinical psychology, each of these professions is governed by one or more national or international organizations and has networks of accredited training programs, well-established research traditions, and specific licensing or certification requirements. Each group also has its own unique history. Practitioners from each group offer mental health services in one form or another. In the following sections, we explain the similarities and differences between clinical psychologists and these other professionals.

Counseling Psychology. Counseling psychologists are the most similar to clinical psychologists in their training and in the types of services 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. Like clinical psychologists, counseling psychologists may hold a Ph.D., Psy.D., or Ed.D. degree. Students in the two fields apply to the same list of accredited internship sites, and graduates in either field are eligible for the same licensure, practice opportunities, and insurance reimbursement. In fact, these two subfields are similar enough that some have called for them to merge (Norcross, 2011). Nevertheless, there are a few notable differences between clinical and counseling psychology.

For one thing, clinical psychology programs are invariably housed in psychology departments. Although some **counseling psychology** programs are located in psychology departments, many are offered through education departments or other university departments or divisions.

Counseling psychology
A psychological human service specialty whose practitioners offer psychotherapy, career counseling, or other forms of counseling related to life changes or developmental problems.

Second, counseling psychology was founded to promote personal, educational, vocational, and group adjustment (Society of Counseling Psychology, 2018). Accordingly, counseling psychologists are more likely to deal with relatively normal transitions and adjustments that people may face, such as conflicts in couples and families, sexual difficulties, and academic problems. Besides offering psychotherapy, counseling psychologists might, for instance, provide career counseling or other forms of counseling related to

life changes or developmental problems. Clinical psychology, in contrast, was founded primarily to assess and treat people 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 those problems. They also generally deal with more severe psychopathology than counseling psychologists do. In other words, most of the differences between the overlapping fields of clinical psychology and counseling psychology are a matter of emphasis and they are generally becoming blurrier over time.

School Psychology. School psychologists have much in common with most clinical and counseling psychologists: they generally use similar training models, satisfy similar internship and licensure requirements, conduct assessments, design interventions at the individual and system levels, and evaluate programs. The most obvious difference is that school psychologists typically receive more training in education and child development than clinical psychologists do, and they focus their assessments and interventions more on children, adolescents, and their families in schools and other educational settings. Despite these differences in emphasis, the similarities between **school psychology** and clinical psychology, and especially clinical child psychology, are greater than their differences (Cobb et al., 2004).

School psychology

A psychological human service specialty whose practitioners focus on testing the cognitive abilities of children and adolescents,

diagnose academic problems, and set up programs to improve student achievement.

Social Work. As the nation's largest single 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 et al., 2012). About one-half of the members of the National Association of Social Workers 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 work
A human service specialty whose practitioners employ various psychotherapy techniques, but also focus on how social and situational variables affect their clients' functioning.

Social workers can earn degrees as a Bachelor of Social Work (BSW), a Master of Social Work (MSW), or less commonly, a Doctorate in Social Work (DSW or Ph.D.). As with clinical psychology, licensing and certification laws vary by state. Typically, the minimum degree required to

provide psychotherapy services is an MSW. Social workers may be trained in various psychotherapy techniques, but as a general rule they focus less on intrapersonal and interpersonal variables and more on how social and situational factors such as inadequate neighborhood resources and other community-wide stressors affect their clients' functioning.

Psychiatry. One of the first questions students ask when they begin studying psychology is "What's the difference between a clinical psychologist and a psychiatrist?" The most entertaining answer is "about $80,000 per year," but the real difference lies in how psychiatrists and clinical psychologists are trained. **Psychiatry** is a specialty within the medical field. So, just as pediatricians focus on children, ophthalmologists specialize in problems of the eyes, and neurologists focus on the brain and the rest of the nervous system, psychiatrists are medical doctors who specialize in understanding and treating psychological disorders. Training to be a psychiatrist typically includes graduation from medical school, and then completion of a four-year psychiatric residency. Residents take course work in psychology and work with patients under the supervision of qualified psychiatrists. The residency often takes place in a psychiatric hospital where the psychiatrist-in-training will encounter some of the most serious forms of psychopathology, but it may also occur in outpatient settings; that is, where patients are not confined for evaluation or treatment.

Psychiatry

A medical specialty whose practitioners provide psychotherapy as well as medication for the treatment of psychological disorders.

Though psychiatrists are qualified to offer psychotherapy, not all of them do. They are also qualified to prescribe medication for the treatment of disorders, which the majority of them do, so the time they spend with patients is often focused on selection and management of that medication (Kane, 2011). In fact, recent research suggests that psychiatrists are spending less time talking to patients and more time prescribing medication and ordering or conducting medical tests than they did in previous decades (Olfson et al., 2014). Some psychiatrists teach, do research, work in administration, and perform other tasks consistent with their level of training. In short, psychiatrists generally have far more medical training, whereas clinical psychologists receive more training in psychological assessment and a broader exposure to a variety of clinical assessment and treatment approaches. Perhaps most importantly, clinical psychologists, especially those with Ph.D.s, receive considerably more training in basic psychological science and the methods of psychological research methods than most psychiatrists do.

The distinction between psychiatrists and clinical psychologists once also included an emphasis by psychiatrists on the importance of biological causes of psychological disorders and an emphasis by clinical psychologists on psychological ones. Recent years, however, have seen increased collaboration between the professions, both in theory and practice. Much of the change can be attributed to the growing realization that psychological disorders are not entirely biological *or* psychological in origin; they are typically a complex combination of both and, as described in Chapter 3, may in many cases stem from common underlying processes (e.g., Caspi &

Moffitt, 2018). As a result, clinical psychologists are increasingly employed in medical settings, where their psychological and research expertise is valued. Psychiatrists and psychologists also often work together on task forces devoted to improving the quality of diagnosis and treatment of psychological disorders. These developments are consistent with a broader shift toward clinical psychology becoming a health profession rather than strictly a mental health profession (Rozensky, 2011).

Other Specialties Related to Clinical Psychology. Still other mental health specialists are trained outside of psychology in programs specifically devoted to their 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 led by a psychiatrist and includes one or more clinical psychologists. They may be trained in some forms of therapy, often those of specific relevance to the patient populations they encounter. *Pastoral counselors* typically receive training in counseling from a faith-based perspective. For clients whose religious faith is central to their identity and outlook on life, such counseling can be helpful in treating psychological problems within the framework of that faith.

In Review An Overview of Clinical Psychology

Definition	The field of psychology that involves research, teaching, and services relevant to the application of principles, methods, and procedures for understanding, predicting, and alleviating cognitive, emotional, biological, psychological, social and behavioral maladjustment, impairment, distress, and discomfort, applied to a wide range of client populations.
Status	The largest single subfield in psychology. Clinical psychologists are designated as health service providers. Its doctoral training programs are the most popular and competitive of any psychological subfield.
Typical requirements for full licensure or certification as a clinical psychologist	A doctoral degree in psychology, a period of supervised clinical experience, and successful completion of one or more examinations, and a record of ethical, competent practice.
Other health service provider subfields in psychology	Counseling, school, child, family, geriatric, clinical neuropsychology, forensic, health, behavior analysis, rehabilitation, sport.
Health service provider fields outside of psychology	Psychiatry, social work, psychiatric nursing, pastoral counseling.
Test Yourself	

1. Clinical psychologists who wish to offer direct service to the public must have either a ______ or a ______degree in psychology.

2. Clinical psychologists are usually portrayed in movies and on television in ways that __________reflect the characteristics and abilities of real therapists.

3. The ethical standards that apply to practicing clinical psychologists ______apply to those who only do teaching, research, and administration.

You can find the answers in the Answer Key at the end of the book.

Paraprofessionals, psychological assistants, psychiatric aides, and others with similar titles, usually have had bachelor's-level or associate-level training that qualifies them to administer a specific form of care or 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, rigorous research traditions, and journals whose articles are peer-reviewed; that is, carefully screened for quality by other scholars prior to publication.

In contrast, many other specialties, such as aromatherapy, reflexology, homeopathy, and spiritual healing techniques, have few or none of the indicators of professional quality just listed and operate further from the mainstream of mental health services. Often classified as *complementary and alternative treatments* or *alternative medicine,* many of these services combine somatic (bodily) or sensual experiences with variants on psychological, social, or spiritual intervention. Some of these practices derive

from ancient traditions; some are new. Those 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; National Center for Complementary and Integrative Health, 2018). Nevertheless, it is wise to remember the principle of *caveat emptor* (“buyer beware”) in relation to such interventions. Some of them, such as homeopathy, are highly questionable because well-controlled scientific experiments have consistently found their effects to be no better than a “sugar pill” placebo (Ernst, 2010).

Clinical Psychologists at Work

Section Preview In this section, we consider in more detail the activities that clinical psychologists pursue, how much time they tend to spend in those activities, the variety of places where they are employed, the array of clients and problems on which they focus their attention, and the financial rewards of their jobs.

What Do Clinical Psychologists Do?

Clinical psychologists engage in many different, interesting, and challenging activities. Not all clinicians are equally involved with all of them, but the fact that there is such a wide range of options open to those who enter the field helps to explain why clinical psychology remains so attractive to so many students.

As shown in Figure 1.2, about 92% of all clinical psychologists spend their working lives engaged in some combination of six activities: assessment, treatment, research, teaching (including supervision), consultation, and administration. Of course, the percentages in this figure vary considerably across work settings—clinical psychologists who work in college and university settings spend more time engaged in teaching and research, whereas those in private practice spend more time conducting psychotherapy and assessment.

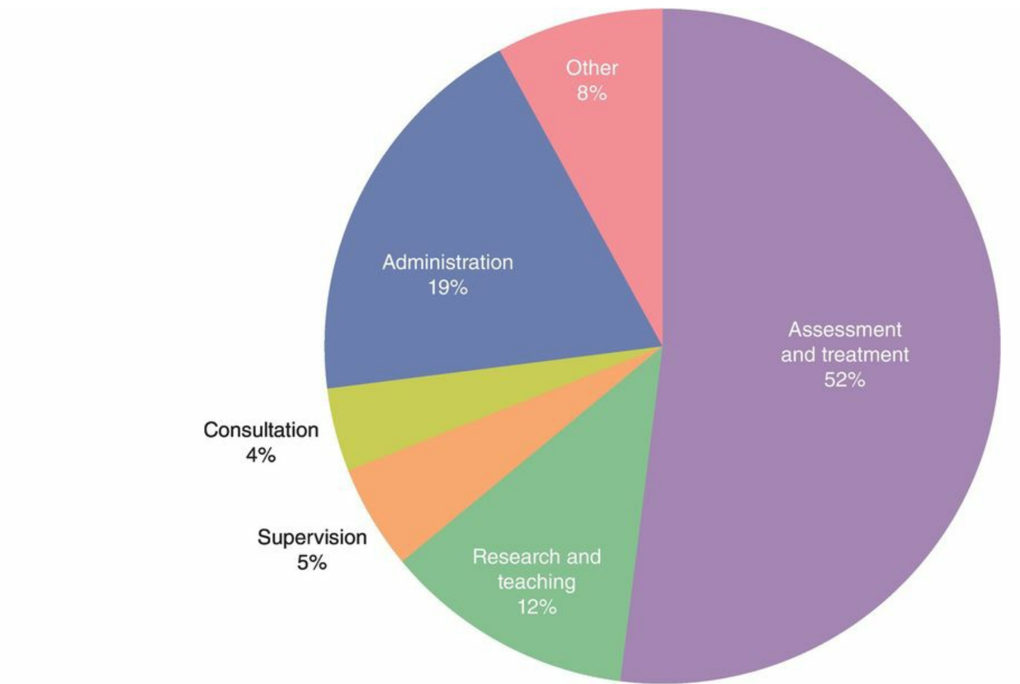


Figure 1.2 Percentage of Time Licensed Psychologists Spend in Professional Activities
As you can see, licensed clinical psychologists spend most of their time providing direct service to clients, but they can be involved in many additional activities as well. The "other" category includes, for example, working in communities to prevent mental disorders.

(Source: Adapted from Hamp, A., Stamm, K., Lin, L., & Christidis, P. (2016). *2015 APA survey of psychology health service providers*. Washington, DC: APA Center for Workforce Studies.)

Assessment. The process of collecting information about people, their behavior, problems, personality traits, abilities, and intellectual functioning, is known as **assessment**. This information may be used to diagnose problematic behavior, guide a client toward an optimal vocational choice, facilitate selection of job candidates, describe a client's personality characteristics, select treatment techniques, guide legal decisions regarding the commitment of individuals to institutions, provide a more complete picture of a client's problems, screen potential participants for psychological research projects, 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'll cover each of these in detail in Chapters 3, 4, and 5.

Assessment

The process of collecting information about people's behavior, problems, unique characteristics, abilities, intellectual functioning, and the like.

Clinicians today have a growing array of assessment options available to them. For instance, computers can administer assessment items, analyze results, and even generate written reports. And research on genetic, neurochemical, hormonal, and neurological processes, especially in the brain, has led to the development of new neurobiological assessments that employ functional magnetic resonance imaging (MRI), genome mapping, and other technological advances to identify biological correlates of specific disorders (e.g. Boska, 2013; Demkow & Wolańczyk, 2017).

Treatment. Clinical psychologists offer **treatment** designed to help people better understand and solve distressing psychological problems. These interventions might be described as psychotherapy, behavior modification, psychological counseling, or other terms, depending on the theoretical orientation of the clinician. Treatment sessions may include client or therapist dialogues or monologues, painstaking construction of new behavioral skills, role-playing, episodes of intense emotional expression, and many other activities that range from the highly structured to the completely unstructured.

Treatment

Interventions designed to help people better understand and solve distressing psychological problems.

Conducting psychotherapy with individual clients has long been clinicians' single most frequent activity (Kazdin, 2011), but clinicians may also work with two or more clients at the same time, in couple, family, or group therapy. For example, the problems that brought Rachel Jackson to the attention of a clinical psychologist will ultimately be addressed through therapy sessions with her and her family. Treatment may be as brief as one session or may extend over several years.

Preventing Problems

As you will see in Chapter 10, some clinical psychologists work in the field of *community psychology*, where the focus is not on individual clients, but on preventing psychological problems by trying to change social institutions, reduce environmental stressors, and improve the coping

skills of people at risk for disorder, such as bullied children or teenage parents.

(Source: NurPhoto/Getty Images.)

The results of psychological treatments are usually positive, though in some cases the change may be small or nonexistent. A small subset of therapies may even make certain people worse off (Castonguay et al., 2010; Lilienfeld, 2007). In Chapter 7, we describe some of the research that is aimed at scientifically evaluating the effectiveness of various psychological treatments and helping practicing clinicians and clients to select the best of them.

Research. Evaluating treatment is but one example of the research tradition in clinical psychology. As we describe in the next chapter, it was research, not service delivery, that originally dominated the field of clinical psychology. That emphasis has now largely been reversed, especially among licensed clinicians, but research continues to play a vital role in clinical psychology.

In fact, their **clinical research** activity is what makes clinicians stand out from other health service providers, and we believe that it is through research that they make their most exceptional and significant contributions. 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) of psychotherapy research has now evolved into an “experimental” era in which the quality of research has improved greatly and the conclusions we can draw about the effects of therapy are much stronger. Nevertheless, as you will see in later chapters, the ultimate strength of those conclusions will

depend on the extent to which the results of many kinds of clinical research can be replicated (repeated) by independent investigators. In other words, clinical researchers still have their scientific work cut out for them (Tackett et al., 2017).

Clinical research
Gathering and analyzing evidence related to disorder, assessment, and treatment; an activity that helps clinicians stand out from other health service providers.

Research in clinical psychology varies greatly with respect to its setting and scope. Some studies are conducted in research laboratories, and some in clinics and other more naturalistic, but less controllable, conditions. Some research 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.

Evaluating New Treatment Approaches

Clinical researchers are studying the use of virtual reality (VR) technology to help clients overcome troubling phobias. Here, a client wears a VR display that presents gradually more challenging images of feared situations; in this case, heights. In Chapter 9, you can learn more about the role of VR in learning-based approaches to the treatment of anxiety disorders.

(Source: Boris Horvat/Staff/AFP/Getty Images.)

The tradition of research in clinical psychology is reflected in graduate school admission criteria, which often emphasize applicants' experience 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. So even though most clinical psychologists do not pursue a research career—some never publish a single paper—most graduate programs in clinical psychology still devote a significant amount of time to training their students in research skills. Why?

There are at least four reasons. First, it is important that all clinicians are able to critically evaluate published research so that they can determine

which assessment procedures and therapeutic interventions are most likely to be effective for their clients. Second, clinicians who work in academia must often supervise and evaluate research projects conducted by their students. Third, research training can be very valuable when psychologists who work in community mental health centers or other service agencies are asked to assist administrators in evaluating the effectiveness of agency programs. Fourth, research training can help clinicians to better evaluate the effectiveness of their own clinical work. Tracking objective evidence of changes in a client's symptom profile can signal that a treatment program is on the right track, that it is time to adjust it in some way, or even that the clinician might need additional training (Lambert, 2015). Such evidence can also contribute to data being collected by clinical researchers and insurance companies in an effort to document and understand factors affecting clinical effectiveness (Hatfield & Ogles, 2004).

Teaching. A considerable amount 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 may also conduct specialized graduate seminars on advanced topics, and 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. The research supervisors then help their students to frame appropriate research questions,

apply basic principles of research design to address those questions, and hone the research skills needed to conduct the project.

Clinical psychologists also do a considerable amount of teaching in the context of in-service (that is, on-the-job) continuing education programs for psychological, medical, or other interns, social workers, nurses, chiropractors, dentists and dental assistants, 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 psychological sophistication. Clinicians even teach while doing therapy—particularly if they adopt the cognitive behavioral approach described in Chapter 2, in which treatment includes helping people learn more adaptive ways of thinking and behaving. Practicing clinicians may also teach part-time in colleges, universities, and professional schools of psychology. Working as an adjunct faculty member provides an additional source of income, but many clinicians teach because it is an enjoyable way to share their professional expertise and, in the process of preparing their classes, to remain abreast of the latest developments in their field.

Consulting. Clinical psychologists commonly provide advice to organizations about a variety of problems. As consultants, clinicians 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 organizational conflict (e.g., by altering personnel assignments). It is perhaps because **consulting** entails such a challenging combination of activities that some clinicians find the work so personally and financially satisfying that it becomes their full-time job. The organizations that seek clinical consultants'

expertise range from one-person medical or law practices to large government agencies, schools, hospitals, and multinational corporations. Consultants may also work with neighborhood associations, walk-in treatment centers, and many other community-based organizations.

Consulting
A function performed by clinical psychologists that includes offering education, advice, assessment, treatment, evaluation, and conflict resolution services to many kinds of organizations.

When consulting is *case* oriented, the clinician focuses on a specific 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 clinical consultant might 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 administrator awareness of the psychological impact that their decisions have on employees. This kind of consulting overlaps considerably with the work of some industrial/organizational psychologists (Khanna, Medsker & Ginter, 2013).

Administration. Many clinical psychologists find themselves engaged in **administration**, which typically involves managing or running the daily

operations of organizations. A clinician might be the 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 or community mental health center, manager of a government agency, director of the psychology service at a Veterans Administration (VA) hospital, or serve in other administrative roles. As you might expect, these administrative duties tend to become more likely as clinicians gain more and more experience in their careers.

Administration
A function in which clinical psychologists serve as managers of various kinds of organizations.

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

Where Do Clinical Psychologists Work?

As you will see in the next chapter, there was a time when clinical psychologists worked only in child guidance clinics. Today, their work settings are far more diverse, and many clinicians work in more than one of them. Here is a partial list of these settings (Table 1.1 shows which settings are most popular):

- college and university psychology departments
- law schools
- public and private medical and psychiatric hospitals
- juvenile offender facilities
- city, county, and private mental health clinics
- community mental health centers
- student health and counseling centers
- medical schools
- the military
- public and private schools
- institutions for the intellectually disabled
- police departments
- prisons
- probation departments

- business and industrial firms
- rehabilitation centers for the handicapped
- nursing homes and other geriatric facilities
- orphanages
- alcoholism treatment centers
- child treatment centers

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

The majority of clinical psychologists, like other health service providers in psychology, work in direct service settings, but may also engage in other activities in a secondary workplace.

Setting	**Primary Setting (%)**	**Secondary Setting (%)**
Private practice	45	47
Hospitals	17	10
Other human service settings	7	6
Academics	19	21
Business and Government	8	6
Other	4	10

(*Source :* Hamp, A., Stamm, K., Lin, L., & Christidis, P. (2016). *2015 APA survey of psychology health service providers.* Washington, DC:

APA Center for Workforce Studies.)

The places where clinical psychologists work exert a strong influence on how much time they spend on each of their various activities. So does their training, individual interests, areas of expertise, and of course the nature of the job market at any given time. In short, what clinicians can do and where they can do it always depends on the situational demands of their jobs, personal and cultural values, and the ever-changing needs of the society in which they live.

How Much Do Clinical Psychologists Earn?

The financial rewards for employment as a clinical psychologist are substantial. A survey by the APA Center for Workforce Studies (American Psychological Association, 2017c) showed that in 2015, the median annual salary for all doctoral-level clinical psychologists was $80,000. It was $85,000 for those in direct service jobs, and $120,000 for those in private practice. A more recent survey (American Psychological Association, 2018c) found that psychologists (including clinicians) working in academic settings earned a median salary of about $74,000. Of course, individual salaries vary depending on the pay scales prevailing at particular employment settings, on years of experience, quality of performance, and economic conditions. (The latest APA surveys of its members' salaries, employment settings, activities, and many other characteristics are available at http://www.apa.org/workforce/publications/index.aspx.)

Who Are Clinical Psychologists?

The demographic characteristics of clinical psychologists in North America have become increasingly diverse over the years. In 1950, for example, clinical psychology—like most professions, other than teaching and nursing—was dominated by white men (Walker, 1991). Women received only 15% of the doctoral degrees in clinical psychology awarded that year. Today, the figure is nearly 78% (National Center for Education Statistics, 2017). Table 1.2 shows this reversal, as well as the increasing diversity of the clinical psychology workforce as seen in characteristics such as race, ethnicity, and sexual orientation. The percentage of psychologists with disabilities, however, has remained at about the same 5% level since 2007 (American Psychological Association, 2018d).

Table 1.2 Demographic Characteristics of Psychology Health Service Providers (in Percentages)

A recent APA survey of about 5200 doctoral health service providers in psychology, most of whom are clinical psychologists, shows that, compared to those who graduated decades ago, the most recent graduates are more diverse in terms of gender, race, ethnicity, and sexual orientation.

Career Stage	Early (1–10 years postdoctoral)	Mid (11–20 years postdoctoral)	Senior (21–30 years postdoctoral)	Late Senic (31+ years postdocto
Gender				
Female	76.7	72.2	58.7	38.1
Male	23.3	27.8	41.3	61.9

Race-Ethnicity				
White	78.2	84.1	89.4	91
People of color	21.8	15.9	10.6	9
Sexual Orientation				
Heterosexual	91	92.3	92.1	95.4
Gay/lesbian/ bisexual	9	7.7	7.9	4.6

(*Source:* American Psychological Association. (2017d). *Career stages of health service psychologists: Special analysis of the 2015 APA Survey of Psychology Health Service Providers*. Washington, DC: Author.)

Of course, there is a lag of many years between enrollment in a degree program and attainment of senior status within a profession. Partly as a result, there are still more men than women among the most senior clinical psychology faculty in colleges and universities, and more men than women among the higher-salaried private practitioners of clinical psychology. But at all levels, the trend toward gender balance in the psychology and clinical psychology workforce is clear (Lin, Stamm, & Christidis, 2018).

Many colleges and universities have specific recruitment plans for targeting people of color, and many psychology departments have their own department-level strategies for recruiting and retaining those people in their graduate programs. As a result, ethnic minorities now make up approximately 33% of new doctoral degree recipients in clinical psychology, a significant increase from approximately 8% in 1977 (National Center for Science and Engineering Statistics, 2017). Hispanic Americans represent the highest

percentage of racial or ethnic minorities among clinical psychology graduates (9.1%), followed by African Americans (5%), Asian Americans (4.98%), people of mixed race (2.3%), and Native Americans (0.002%).

Table 1.2 shows that a somewhat wider range of sexual orientation is now represented among clinical psychologists. In the most recent APA workforce survey, 90.2% of psychology health service providers identified as heterosexual or straight, whereas 6.9% identified as gay, lesbian, or bisexual. About 0.3% of respondents listed their gender identity as transgender or "other," and 2.6% chose not to respond to this part of the survey (American Psychological Association, 2016b).

The median age of recent doctorates in clinical psychology is 32. That may sound old (perhaps "mature" is a more tactful word) if you are a traditional student in the process of earning your bachelor's degree, but it is the "new normal." 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. Most students complete a clinical doctorate in 5 or 6 years, but some (including one of your authors, S.L.!) take 7 or 8 years, or more. Keep in mind, too, that while these students are working on their doctorates, many are also working a different job, at least part-time, to help pay their bills, and this almost invariably slows their progress.

Who Are the Clients of Clinical Psychologists?

The growing diversity of clinical psychologists in North America parallels the increasing diversity they see in their clients. The United States is already one of the world's most ethnically and racially diverse countries, and it is projected that by 2045, only 49.9% of the U.S. population will consist of non-Hispanic Whites (Frey, 2018). The rest are expected to be Hispanic (24.6%), African American (13.1%), Asian American (7.8%), or multiracial (3.8%). A larger proportion of Americans will have been born in other countries—or, like Rachel Jackson's mother, Lena, will have parents who were—than has been the case for decades. These characteristics of the general population will continue to bear significant implications for clinical psychology.

For example, people from different backgrounds may have different ways of expressing psychological distress, meaning that clinicians and clinical researchers must be highly sensitive to cultural variations in the symptoms and expression of psychological disorders (Alcantara & Gone, 2014; Kim & Lopez, 2014). As a case in point, there is some evidence that individuals in Asian cultures are more likely to express psychological distress in the form of unexplained bodily symptoms rather than report depression or anxiety (Choi, Chentsova-Dutton, & Parrott, 2016). Responses to treatments can also vary depending on clients' backgrounds. Even willingness to seek psychological help can vary as a function of culture, ethnicity, associated differences in the stigma surrounding mental illness, and prior experiences with low-quality care because of factors such as discrimination. African Americans, for instance, tend to be more reluctant to seek out psychological treatment than Whites (Buser, 2009). So today's clinicians and those who are

studying to be clinicians need specialized training to help them conduct meaningful research with—and provide culturally sensitive services to—the increasingly diverse client groups with whom they come in contact (American Psychological Association, 2016b; Hall, 2005; Sehgal et al., 2011).

Client diversity is not limited to their demographic characteristics. It also appears in the types of problems clients bring to clinical psychologists. National surveys (Bagalman & Cornell, 2018; Kessler et al., 2012) show that the most common difficulties are anxiety disorders (e.g., specific phobias, panic disorder), impulse-control disorders (e.g., intermittent explosive disorder), mood disorders (e.g., depression), and substance-related disorders (e.g., abuse of alcohol or illegal drugs). Yet only about one-half of the people who receive treatment actually meet the criteria described in Chapter 3 for an “official” disorder diagnosis (Kessler et al., 2005). Their problems include difficulties in interpersonal relationships, problems with their intimate partner, difficulties at school or work, psychosomatic and physical symptoms, and so on. The overall prevalence and types of problems for which people seek help, or who are referred for help, have remained about the same over the years, suggesting that the need for clinical psychologists has not declined, and probably will not decline much in the future.

In Review Clinical Psychologists at Work

Common activities	Assessment, treatment, research, teaching (including supervision), consultation, and administration.
Primary work settings (in order of popularity)	Private practice, academia, hospitals, business and government, other human service settings.
Median annual salaries	Overall median: $80,000 Direct service median: $85,000 Private practice median: $120,000 Academic job median: $74,000.
Demographic characteristics	Increasing diversity in recent years. Almost 80% of the newest doctoral graduates are women, almost 22% are people of color, and nearly 10% identify as lesbian, gay, or bisexual.

Test Yourself

1. The most common activity for licensed clinical psychologists is ____________, delivered in the context of a ________________ setting.

2. ________is an activity that distinguishes clinical psychologists from other health service providers.

3. Clinical psychologists' clients are more diverse than ever, making it necessary that they have training in ____________________.

You can find the answers in the Answer Key at the end of the book.

Clinical Psychology in the 21st Century

Section Preview In this section, we describe some of the most important and controversial questions being debated in clinical psychology today. The first of them focuses on the extent to which the practice of clinical psychology should influence—and be influenced by—scientific research on behavior and behavior disorders. Another key question is how best to blend the knowledge that comes from scientific research with that coming from clinical experience, personal judgment, and clients' preferences. The field is also wrestling with the question of whether researchers and practitioners should continue to adhere to one of the traditional "schools" or theoretical orientations in clinical psychology, or if they should become more theoretically unified by identifying the common principles that those orientations share. We will also address questions raised by the impact of managed health-care systems, legislative actions, and other social and cultural factors on the practice of clinical psychology and on health-care delivery.

Science and Practice

Some of the liveliest discussions within clinical psychology involve the extent to which the practice of clinical psychology should be driven by research that shows what tends to work best with the "average" client, or by what a clinician's judgment and experiences say would work best with a particular client. If the science says one thing but a clinician has a different perspective, which view should prevail? Or should both be weighted equally? These questions are complex and have a long history, so in this chapter we introduce only their broad outlines and some of their major implications. We'll discuss them in greater detail in Chapters 2, 10, and 15.

Recall that the APA definition of clinical psychology includes both the *science* of clinical psychology and the *practice* of clinical psychology. Still, this definition is silent on such crucial questions as *how* science and practice should be integrated, and how those decisions should be made. The answers to these questions have implications far beyond philosophical debates at psychology conferences. They affect how clinicians are trained, how clients are treated, how research is conducted, and how clinical psychology is viewed in the health-care delivery system and in the public eye.

Evidence-Based Practice. Imagine going to a physician who ignores the results of medical research and modern methods of diagnosis and treatment in favor of intuition, outdated training, and folklore. If you had expected state-of-the-art service, your first visit to that doctor would probably also be your last. Most people understandably prefer to consult medical practitioners whose professional services are based on the latest research in

the field. That type of professional is said to be engaged in evidence-based practice (EBP; Institute of Medicine, 2001; Sackett et al., 1996, 2000).

Evidence-based practice in clinical psychology was endorsed as official APA policy in 2005 (APA Presidential Task Force on Evidence-Based Practice, 2006), largely because there is little doubt that clinical psychologists should base their practice decisions on a combination of the best available scientific evidence, personal judgment and experience, and the characteristics, preferences, and needs of clients. As always, however, the devil is in the details. Evidence-based practitioners are expected to choose diagnostic and therapeutic methods that high-quality evidence has found to be most effective, but the definition of "best" is not always clear (Stuart & Lilienfeld, 2007). Suppose that an experiment shows Treatment A to have a statistically significant advantage over Treatment B when both were administered under laboratory conditions by therapists trained to use therapy manuals with volunteer clients who were all about the same age and who all displayed the same type of disorder, such as mild depression. Would Treatment A work just as well with clients of varying ages or ethnic backgrounds, who have somewhat more severe disorders, and who are seen in a private practitioner's office? It might, but it might not. Clinicians must remember that the value of scientific evidence depends not only on the quality of the research designs that generated it (its *internal validity*), but also on the broader applicability of the evidence (its *external validity*). So clinical psychologists, like the one who will be seeing Rachel and her family, know that it is important to stay in touch with high-quality scientific evidence regarding effective family therapy methods, but they must also consider how useful that evidence is for guiding their practice.

Thinking Scientifically About Evidence

To clinical scientists, evidence-based practice includes always *thinking scientifically* about research. By **scientific thinking**, we mean thinking that helps us to minimize error in the conclusions we draw from evidence. With regard to the experiment we just described, for example, they would want to ask themselves the following questions:

1. ***What am I being asked to believe?*** (That Treatment A is better than Treatment B.)

2. ***What kind of evidence is available to support the claim?*** (A controlled laboratory experiment showed Treatment A to work better than Treatment B with a particular type of client and disorder.)

3. ***Are there alternative ways to interpret the evidence, including those that my biases and preconceptions might have kept me from seeing?*** (Perhaps Treatment A was just more impressive to clients than Treatment B. Maybe the therapists had more confidence in Treatment A and therefore conducted it more carefully. Would the results be different for clients with different kinds of disorders? Was the *statistically* significant superiority of A over B large enough to be *clinically* significant—that is, to make a noticeable difference in clients' lives?)

4. ***What additional evidence would help evaluate the alternatives?*** (Additional studies with a wider range of clients and disorders in real clinical settings, along with information about what treatments a given client has tried previously, what treatment the client prefers, and the feasibility of offering Treatment A given the clinician's setting and experience.)

5. ***What conclusions are most reasonable given the kind of evidence available?*** (If Treatment B is the one a particular client would prefer and I think it is a good match to the client's background and needs, I may want to wait for more evidence about Treatment A before offering it to this client. However, if I have never used either treatment and the client is open to it, I should probably try Treatment A rather than B.)

In short, evidence-based practitioners pay attention to laboratory research evidence, but they recognize the importance of other sources of evidence, too, including that coming from clinical experience, and from what they have learned about the values and preferences of their clients (see Figure 1.3). These three sources of information are built into the APA definition of **evidence-based practice** in psychology, which requires the integration of the best available research evidence with clinical expertise in the context of patient characteristics, culture, and preferences (American Psychological Association, 2006; see also Chapter 7).

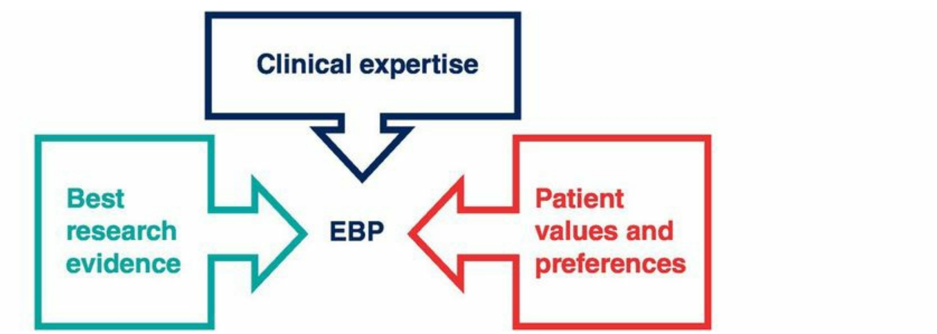


Figure 1.3 Sources of information for Evidence-Based Practice (EBP): A Three-Legged Stool
Evidence-based practice is guided by three elements: research evidence, clinical judgment and experience, and client preferences and values. Clinicians who engage in evidence-based practice recognize the

importance of all three in shaping the decisions they make about how to conduct their assessment and treatment services.

Scientific thinking
A way of thinking that helps to minimize error in the conclusions we draw from evidence.

Evidence-based practice
Psychological services that integrate the best available research with clinical judgment and expertise in the context of patient characteristics, culture, and preferences.

But the APA definition still leaves room for debate among psychologists who differ over which of the three sources of information should be given the most weight (e.g., Norcross & Wampold, 2019). Some would like to see practice decisions shaped more by evidence from clinical experience than from clinical research, whereas others would like to see just the opposite. Clinical research evidence carries the heaviest weight for most clinical psychological scientists who are not APA members. This can be seen in the definition of evidence-based practice adopted by the Canadian Psychological Association (CPA, 2012), and by clinical psychological scientists in the

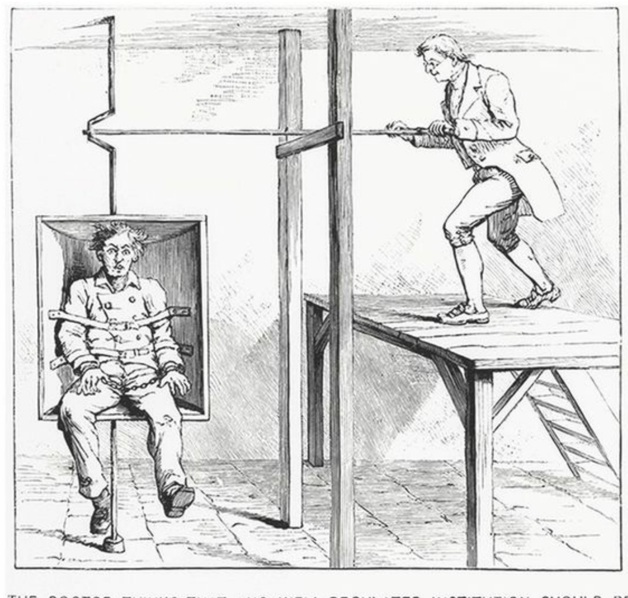
Association for Psychological Science (APS; Baker, McFall, & Shoham, 2008). Many of those APS members are researchers and directors of clinical training whose departments of psychology promote the value of scientific clinical psychology through membership in an organization called the Academy of Psychological Clinical Science.

Our own perspective, which we describe in more detail in Chapter 7, recognizes both clinical experience and empirical evidence as crucial elements in the evaluation of clinical assessments and psychological interventions, but we tend to emphasize the latter. For example, we see clinical experience as a valuable starting point for *generating* hypotheses about what makes psychotherapy effective, or about promising new therapies, but if certain therapy techniques perform poorly in repeated clinical trials with a representative range of clients, we would argue that those techniques —even time-honored ones—should be abandoned in favor of those that have been shown to perform better.

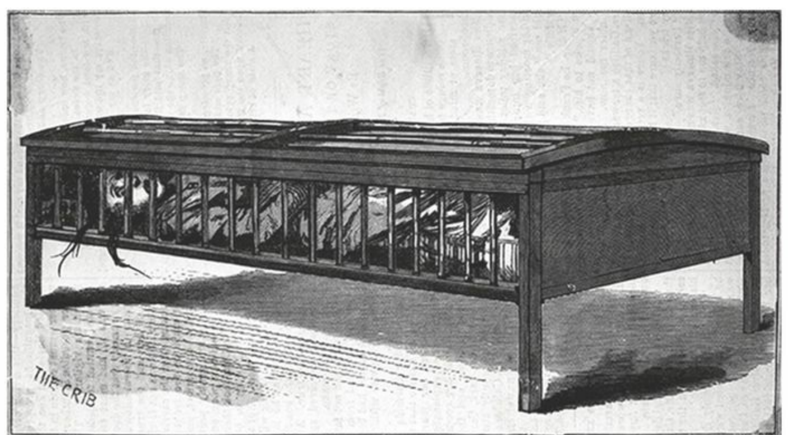
We take this position partly because the histories of both medicine and psychology teach us that relying solely on clinical experience and intuition can lead to incorrect conclusions. This was the case for many centuries when physicians were convinced that bloodletting through cuts or the attachment of leeches were effective treatments for many physical disorders. They were wrong (Grove & Meehl, 1996). So were early generations of psychiatrists, described in Chapter 2, whose clinical experience told them that mental hospital patients could be helped by periods of confinement in spinning chairs or narrow cribs (Whitaker, 2001) (see Figure 1.4).

Figure 1.4 Experience is Not Always the Best Teacher

The hazards of overreliance on clinical experience and intuition to guide treatment selection can be seen in the use of such ineffective devices as “whirling chairs” (upper left), tranquilizing chairs (upper right), and Utica cribs by doctors in 18th century mental hospitals in Europe and North America.



THE DOCTOR THINKS THAT "NO WELL-REGULATED INSTITUTION SHOULD BE UNPROVIDED WITH THE CIRCULATING SWING." 1818.



(Source: Corbis Historical/Getty Images; Bettmann/Getty Images; Bettmann/Getty Images.)

There is some urgency for clinical psychology to reach a consensus about what constitutes the best treatment practices and about how to train and update clinicians in those practices. The time pressure exists because some local and state government agencies as well as some insurance providers have

constructed lists of the psychotherapies for which they will provide reimbursement to clients or their therapists (Norcross, Beutler, & Levant, 2006). They are making these lists on the basis of their budgets and *their* understanding of which therapies are most effective, regardless of what clinical psychologists have identified as best practices. To many psychologists, this is not a welcome development because clinical researchers and practitioners are more knowledgeable about these matters than insurance companies, so they believe that they and their professional associations should be more active in establishing lists of the most effective treatments for various psychological disorders.

As described in Chapter 7, the efforts of these psychologists have resulted in lists of empirically supported therapies (Chambless & Ollendick, 2001), and in the publication of general guidelines for implementing them (APA Presidential Task Force on Evidence-Based Practice, 2006). In 2010, for the first time, the APA began a process to develop evidence-based guidance for the treatment of specific disorders (Kurtzman & Bufka, 2011). Guidelines have already been created for treating posttraumatic stress disorder, childhood obesity, and depression, and others are in development (e.g., American Psychological Association, 2017b). So the call for evidence-based practice has become a rallying cry among clinical practitioners even though they may disagree about exactly what it means (Goodheart, 2001; Kazdin, 2011).

Clinical Psychology Training. Decisions about the most desirable mix of science and practice obviously affect how students are trained in clinical psychology (e.g., Baker, McFall, & Shoham, 2008). Two models for structuring that training—each named for the Colorado city where they were developed—have long dominated the scene, but a third one has recently

emerged. The first approach, called the *Boulder model*, arose out of the first major training conference in clinical psychology, held in 1949 at the University of Colorado at Boulder (Raimy, 1950). Also referred to as the **scientist–practitioner** model, the **Boulder model** recommended that clinical psychologists should complete a Ph.D. in psychology at a university-based graduate program that places heavier emphasis on scientific research than on preparation for clinical practice. Even so, the model also requires completion of a supervised, year-long internship. A more recent conference, this one at the University of Delaware in 2011, recommended that Boulder model training be refined so as to prepare clinical scientists to not only conduct research, but to translate the results of that research into practice recommendations that are likely to be widely adopted by practitioners and service organizations (Shoham et al., 2014). The *Delaware Project*, as it has come to be called, also highlights the importance of training clinical researchers broadly in basic psychological science, such as biopsychology, emotion, cognition, and learning theory, so that they can collaborate effectively with psychologists in other domains.

Boulder model (scientist–practitioner model)

A form of clinical psychology training that includes a Ph.D. from a university-based graduate program that emphasizes preparation for clinical research over clinical practice.

The second main training approach originated in 1973 at the National Conference on Levels and Patterns of Professional Training in Psychology at Vail, Colorado. The **Vail model**, sometimes called the **practitioner–scholar** model, places proportionately less emphasis on scientific training and more on preparation for the delivery of clinical services (Korman, 1976). Graduates of practitioner–scholar programs are trained primarily to conduct psychotherapy and clinical assessments but, ideally at least, they are also taught how to interpret and apply clinical research in the treatment of their clients. The Vail delegates proposed that, when training emphasizes the delivery and evaluation of professional services, the most appropriate degree is the Psy.D. (Doctor of Psychology) rather than the Ph.D. They also suggested that clinical psychology training programs don't all have to be housed in university psychology departments. These practice-oriented programs can also operate, they said, in medical schools and in freestanding schools of professional psychology, many of which are based in large office buildings. Advocates of this training model see independent schools as having status equal to that of more traditional university-based scientist–professional training.

Vail model (practitioner–scholar model)
A form of clinical psychology training that usually results in a Psy.D. degree and focuses more on preparation for clinical services rather than clinical research.

The third, and most recent training approach is called the **clinical science model**. It is based on the idea that every aspect of clinical psychology training should be scientifically based (McFall, Treat, & Simons, 2015). This model rejects the hyphen in the scientist–practitioner model, which has typically been taken to imply that one can be either a scientist or a practitioner (or in some cases, both). Instead, the clinical science model argues that all clinical psychology programs must infuse scientific principles and knowledge into all aspects of graduate study, including research, clinical practice, and teaching. This model also contends that students should be given rigorous training in the delivery of evidence-based assessment and treatment techniques (see Chapter 15 for much more discussion of clinical training models).

Clinical science model

A form of clinical training in which every aspect of graduate study is based on scientific evidence.

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, behavioral, cognitive behavioral, humanistic, or social systems. Is this the best way to organize clinical psychology training? Some have expressed concern that a theory-based approach to clinical training has created divisiveness within the field, so that many of those who have pledged allegiance to one orientation reflexively dismiss research and theory supporting other approaches (Gold & Strickler, 2006). This reaction is problematic for two reasons. First, there is seldom a compelling empirical reason to adhere to only one theoretical approach; they all have their strengths and weaknesses. Second, maintaining a focus on a particular set of theory-based methods may impair clinicians' ability to recognize that differing theoretical approaches may all include similar mechanisms of change, and that helping clients depends more on promoting these change mechanisms than it does on the specific treatment methods employed (e.g. Hofmann & Hayes, 2019). As a result, many or most clinical psychologists now favor an approach in which it is acceptable, and even desirable, to employ techniques from a variety of "schools" rather than sticking to just one—as long as the choices are based on evidence-based principles of change. This approach is sometimes called *eclecticism*. Be aware, though, that there is an important difference between theoretical and technical eclecticism (Beutler & Consoli, 1992; Beutler et al., 2016; Lazarus, 1967). *Technical eclecticism* refers to employing one primary theoretical position as a basis for explaining the origins of disorder, identifying the

change processes that are most important in therapy, and making a treatment plan, but being willing to draw on useful techniques from multiple therapeutic models to bring about therapeutic change. *Theoretical eclecticism* refers to holding no clear or coherent theoretical orientation to guide one's view of disorder, and being willing to draw on various techniques based on whatever seems interesting or convenient. To clinical scientists, technical eclecticism is the far more desirable option.

Eclecticism is closely related to the idea of *psychotherapy integration*, which, as described in Chapter 15, involves the systematic combination 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 the knowledge of when and how to use them, makes for an effective psychotherapist. Indeed, surveys suggest that most therapists now identify themselves as *eclectic* (Santoro et al., 2004), and there is now a journal—the *Journal of Psychotherapy Integration*—devoted to integrating various therapy approaches.

But integration and eclecticism are not easy to achieve. How should theories and practices be combined? How can we ensure that clinicians are integrating clinical techniques in a thoughtful manner rather than just picking them out and administering them capriciously? 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? These important questions will no doubt receive continued attention in future years (Ivey & Deans, 2019; see our discussion of future directions in clinical psychology in Chapter 15).

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. Recent years have seen significant changes in the health-care laws that affect the practice of clinical psychology.

Mental Health Parity. In the United States prior to 2008, mental health problems were regarded by health insurance companies as less deserving of consideration than other health problems. That's partly because people were seen as having greater personal responsibility for their psychological problems than for their medical ones, and partly because, compared to medical problems, psychological problems are often more difficult to define. The idea that people are responsible for their own psychological problems might have made more sense a century ago when the most severe physical ailments were infectious diseases—smallpox, typhoid, diphtheria, for example—and when psychological disorders were still not recognized as stemming from the interplay of biological, psychological, and social factors. But few people today who understand the origins of psychological disorders would argue that people freely choose to have psychological problems. And as we describe in Chapter 12, personal lifestyle choices are now recognized as playing a role in triggering or worsening heart disease, diabetes, some forms of cancer, and many of today's other most serious physical health problems. Negative attitudes toward people with psychological disorders have certainly not entirely disappeared (Centers for Disease Control and Prevention, 2012). However, as the stigma associated with having a

psychological disorder has diminished (Mind, 2014), disparities in health-care coverage have gradually begun to change. In 2008, the Mental Health Parity and Addiction Act (MHPAA) became federal law in the United States. **Mental health parity** requires that health insurers provide the same level of coverage for psychological disorders as they do for physical disorders, meaning that clinical psychologists and other psychological health-care providers are entitled to reimbursement for their services.

Mental health parity
A legal requirement that health insurers cover treatment for psychological disorders to the same extent as for physical disorders.

Managed Care. Mental health parity is just one example of how clinical psychology training, practice, and research are affected by the ways in which health-care systems are structured. Whereas clients once paid providers directly for services, most health care, including mental health care, now involves three parties: client, clinician, and an insurance company, a Health Maintenance Organization (HMO), or some 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 ever-greater influence over psychological treatments, clinicians have been forced to adapt. Sometimes, they experience a culture clash between themselves and managed-care companies, complaining that they sometimes have to violate standards of care or ethics in order to be paid (e.g., Cohen, Marecek, & Gillham, 2006). The influence of managed care helps to explain why the salary discrepancy mentioned earlier between private practice and other areas of clinical work is now smaller than it used to be. Most managed-care companies reimburse about equally for psychologists, psychiatrists, social workers, and the like, in part because most research evidence suggests that all these professionals are about equally effective therapists (Dawes, 1994) No wonder, then, that in general, clinicians dislike managed care.

Though the relationship between managed care and clinical psychology has sometimes been rocky (as it has been between managed care and other health professions, too), it is not entirely negative (Bobbitt, 2006; Wilson, 2011). We have already mentioned one positive effect of managed care, namely motivating research on which treatments are most effective for which problems. Managed care has also encouraged practitioners to more precisely measure the outcome of their treatments and to be more mindful of the need to monitor their clients' progress throughout therapy. Finally, managed care has fueled greater emphasis on research aimed at preventing disorders (Silverman, 2013). It is in the interest of clients, clinicians, *and* insurers to know which interventions have the most positive and lasting value for promoting mental health and preventing mental disorder, because that information, correctly applied, will ultimately lower costs and improve client well-being.

Clinical psychologists are continuing to adapt to the ever-changing

world of third-party payment. Often, this means adjusting their services to better match those for which managed-care systems will pay. This adaptability makes sense, but it can lead to problems if managed-care policies and personnel are invariably allowed to make the kind of important treatment decisions that should be reserved for mental health professionals.

Prescription Privileges for Clinical Psychologists. Another aspect of the health-care environment that has major implications for the practice of clinical psychology is the possibility that clinical psychologists, like psychiatrists and other physicians, be authorized to prescribe drugs for the treatment of psychological disorders. In 2002, New Mexico became the first U.S. state to pass a law that gave prescription privileges to licensed psychologists who had completed a lengthy and standardized training curriculum on medications and prescription practices. In 2004, Louisiana did the same and, today, appropriately trained clinicians have prescription privileges in Iowa, Idaho, and Illinois, as well as in Guam, the U.S. military, and the Indian Health Services. Only small numbers of psychologists in these places actually prescribe medication, though, because so few have elected to undergo the extensive training needed in order to do so.

The trend toward psychologist prescription privileges is controversial. Those who support it point to widespread public acceptance of medications for psychological problems, fueled in part by pervasive television and print advertising by drug companies. They argue, too, that clinical psychologists so often deal with clients who are taking psychotropic medications that they may be at least as knowledgeable, if not more so, about the effects of these drugs as the general-practice physicians who prescribed them. Proponents also see prescription privileges as valuable because clients are likely to see their psychologists more frequently than their medical doctor, meaning that

psychologists are often in a better position to monitor the effectiveness of the medications.

However, there are also important arguments against the spread of prescription privileges for clinical psychologists, and some of those arguments come from clinical psychologists themselves. One serious concern is that the training necessary to earn prescription privileges may be inadequate (Heiby, 2009). Others worry that as prescription privileges expand, clinicians may find themselves—like their psychiatrist colleagues—spending more time on choosing, monitoring, and managing drugs than they do on psychotherapy (Kane, 2011). If this happens, and there is some evidence that it might, clients will receive less of the services for which clinical psychology is best known and most particularly helpful—namely treatments that encourage clients to develop the kind of long-term coping and problem-solving skills that can make drugs unnecessary (Nordal, 2010). We discuss the pros and cons of prescription privileges in greater detail in Chapter 15.

Models of Mental Health Treatment Delivery. As we mentioned earlier, the evidence base for choosing psychological interventions is stronger than ever (Lambert, 2013), but the primary method of delivering psychological services is still individual, face-to-face psychotherapy. Some wonder, though, whether this delivery system is the most efficient and effective one (e.g., Kazdin, 2011; Kazdin & Blase, 2011). After all, in any given year, almost 20% of the U.S. population meets the criteria for one or more psychological disorders, but most of those in need of psychological services do not receive them (Albee, 2006; Alonso et al., 2013; National Center for Health Statistics, 2015; Olfson, Blanco, & Marcus, 2016).

Furthermore, only a minority of the services these people receive are supported by scientific research (Layard & Clark, 2014).

Treatment at a Distance

Technology-enabled mental health delivery systems help to address the need for psychological services in rural areas where such services may be limited or nonexistent

(Source: AJ_Watt/E+/Getty Images.)

Proposals for more effective treatment delivery systems still include one-on-one psychotherapy, but would add other approaches, too. For example, troubled people who are unlikely to seek face-to-face psychotherapy might be willing to participate in *ehealth* interventions delivered by telephone, video-conference, email or text, or social media, among many other innovative delivery options (e.g., Harwood et al., 2011b; Kazdin, 2011; Miller, 2013a). We consider these alternative models of clinical intervention, and their ethical and clinical implications, in Chapter 10.

In Review Clinical Psychology in the 21st Century

Major developments	Adoption of evidence-based practice and practice guidelines designed to improve clinical service quality and justify third-party reimbursement. Debates over which sources of evidence are most relevant for maximizing the quality of clinical services. Decreasing emphasis on narrowly defined theoretical approaches; recognition of commonalities and potential value of focusing on more general principles of change. Expansion of service delivery models beyond traditional face-to-face therapy; alternatives include many forms of electronic communication.
Models of clinical training	Boulder model; scientist–practitioner mix, with emphasis on research; Ph.D. degree. Delaware Project; a refinement of the scientist–practitioner mix that emphasizes science and also the translation of clinical research into practice recommendations that will be widely implemented. Vail model; scientist–practitioner mix, with emphasis on clinical service; Psy.D. degree preferred. Clinical science model: clinical training based first and foremost on scientific evidence.
Current controversies	Should prescription privileges for clinical psychologists continue to expand?

Test Yourself

1. The quality of a clinical research design affects the study’s ____________validity, while the applicability of the findings affects the

study’s ___________ validity.

2. In thinking scientifically about the results of a psychotherapy research study, the first question an evidence-based practitioner should ask is ___________________________?

3. Evidence-based practice decisions are guided by evidence from _______________, ____________________, and ____________________.

You can find the answers in the Answer Key at the end of the book.

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 psychological disorders. To become a licensed clinical psychologist, students must satisfy a certain set of educational, legal, and personal requirements. 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. Clinical psychology is also distinguished by its emphasis on scientific research and by the diversity of its training models and practice settings. Although many clinical psychologists engage largely or entirely in service delivery, their work should ideally be guided by a scientific mindset aimed at minimizing errors in their inferences. Science and practice are not incompatible; they are two equally essential sides of the same coin.

The diversity that characterizes clinical psychology can be seen partly 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 that of the populations they study and serve. 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 how best to deliver psychological services, especially to people with psychological problems who typically do not seek or have access to those services. Other factors shaping the discipline involve, among others, decisions about how science and practice should best inform one another, how to conceptualize evidence-based practice, how the training of new psychologists should be conducted, how various theoretical approaches to assessment and treatment can be integrated, and how to adjust the practice of clinical psychology to conform to ever-changing health-care laws and managed-care systems.

2

Clinical Psychology's Past, Present, and Future

◈

Contents

The Roots of Clinical Psychology

Clinical Psychology Begins to Grow

Clinical Psychology Branches Out

Looking ahead

Chapter Preview

In this chapter, you will learn about the events that led to the birth of clinical psychology as a science and a profession. You will see that it grew slowly but steadily during the first half of the 20th century, then saw explosive growth both in size and in the diversity of its major theoretical approaches, including the psychodynamic, humanistic, behavioral, cognitive, cognitive behavioral, and social systems, and biological. You will also read the story of how these approaches developed and see an example of how various approaches might be applied in the case of Rachel Jackson, whom you met in Chapter 1. The chapter concludes with a look ahead at some of the latest developments in clinical psychology that will surely shape its future.Anyone born in the United States after about 1960 might assume that the field of clinical psychology has always existed. However, clinical psychology did not emerge as a widely recognized discipline until the beginning of the 20th century and did not begin its rapid development as a profession until the end of World War II in 1945. Since then, the field has seen a lot of changes in its science and practice (Benjamin, 2005; L'Abate, 2013; Resnick, 1997; Routh, 1994; Taylor, 2000). The earliest clinicians would have found it difficult to imagine the popularity of clinical psychology training today, largely because a hundred years ago they were barely tolerated, let alone accepted, either by psychiatrists or by other psychologists.

The Roots of Clinical Psychology

Section Preview In this section, we begin the story of clinical psychology by describing three traditions that shaped the field and continue to influence it: (a) the use of scientific research methods—the empirical tradition, (b) the measurement of individual differences—the psychometric tradition, and (c) the classification and treatment of behavior disorders—the clinical tradition.

The roots of clinical psychology are deep and old, much older even than the discipline of psychology itself. They can be traced back to developments in philosophy, medicine, and several of the sciences.

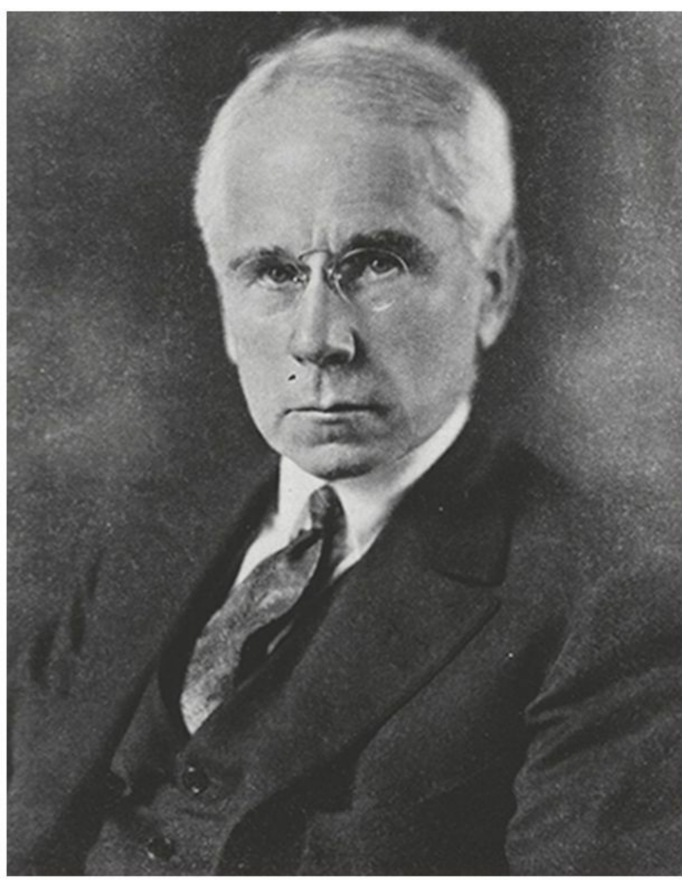
The Empirical Tradition

Historians typically mark the birth of modern psychology as 1879, the year that the German physiologist Wilhelm Wundt (pronounced "voont") established the first formal research laboratory devoted to studying consciousness and other mental processes at the University of Leipzig. Wundt was convinced that psychology—like biology, physics, and other sciences—should seek knowledge through the application of empirical research methods. He and the psychologists who came after him were determined to study human behavior and mental processes by employing the two most powerful tools of science: observation and experimentation.

The founding of Wundt's laboratory was not the only starting point for the new discipline of psychology. Other German researchers working in physiology and medicine had been addressing problems that were essentially psychological in nature. For instance, Johannes Müller and his student Herman Helmholtz identified and studied the neural pathways involved in vision and hearing, and explored the question of how physical energy, such as light, became mental experiences, such as sight. Ernst Weber and Gustav Fechner discovered mathematical formulas that can predict with great accuracy how these mental experiences change as the brightness, loudness, or weight of a stimulus changes. Their findings helped reveal some of the most fundamental ways in which our minds and bodies are connected (Hunt, 1993). Still, Wundt is regarded by most scholars as the founder of psychology because the establishment of his laboratory so clearly proclaimed psychology as a science and because he trained many students who went on to establish psychology programs at other universities in Europe and the

United States. Indeed, the majority of Ph.D. psychologists in the United States can trace their academic lineage back to Wundt.

One of Wundt's early students was an American named Lightner Witmer. After completing his doctorate in 1892, Witmer went to Philadelphia, where he was appointed as the director of the University of Pennsylvania psychology laboratory. It is said that one day in March 1896, a local schoolteacher named Margaret Maguire asked Witmer to help one of her students, Charles Gilman, whom she described as a "chronic bad speller." Perhaps because he had once been a schoolteacher himself, Witmer decided to "take the case," and thus—probably without realizing it—became the world's first clinical psychologist (Benjamin & Baker, 2004; Routh, 1994).



Lightner Witmer (1867–1956)

When a young Lightner Witmer proposed that there should be a field called clinical psychology, many of his colleagues thought he should see a psychiatrist!

(Source: Collections of the National Library of Medicine.)

Witmer's approach was first to assess Charles's problem and then arrange for appropriate remedial procedures. The assessment showed that Charles had a vision problem, as well as some difficulty with reading and memory that Witmer described as "visual verbal amnesia." Today, the boy would probably be diagnosed as having a reading disability. Witmer recommended intensive tutoring to help Charles recognize words without having to spell them first. This procedure eventually made it possible for the child to read normally (McReynolds, 1987).

Charles's case led to the establishment of what became the world's first psychological clinic. By 1900, three children a day were being served by a clinic staff that had grown to 11 members, and in 1907, Witmer set up a residential school for training children with intellectual disabilities. That same year, he founded and edited the first clinical psychology journal, *The Psychological Clinic*, and wrote its lead article, which he titled simply "Clinical Psychology." By 1909, over 450 clients had been seen in Witmer's facilities, and in the fall of 1904, at Witmer's urging, the University of Pennsylvania began offering formal courses in clinical psychology.

Clinical psychology was getting off the ground, but was nowhere near full flight, partly because other psychologists did not support it. This was made clear when Witmer first described his new branch of psychology in a talk at the 1896 meeting of the 4-year-old American Psychological Association. His friend Joseph Collins recounted the scene as follows:

[Witmer said] that clinical psychology is derived from the results of an examination of many human beings, one at a time, and that the analytic method of discriminating mental abilities and defects develops an ordered classification of observed behavior, by means of postanalytic generalizations. He put forth the claim that the psychological clinic is an institution for social and public service, for original research, and for the instruction of students in psychological orthogenics which includes vocational, educational, correctional, hygienic, industrial, and social guidance. The only reaction he got from his audience was a slight elevation of the eyebrows on the part of a few of the older members.

(Quoted in Brotemarkle, 1947, p. 65.)

This chilly reception is understandable given the conditions that prevailed at a time when the field of psychology was itself not yet 20 years old. First, the vast majority of psychologists considered themselves to be laboratory scientists and did not regard the role described by Witmer as appropriate for them. Second, even if they had supported his suggestions, few psychologists were trained to perform the functions he proposed. Third, psychologists were not about to jeopardize their reputation as scientists, which was already fragile enough in those early years, by plunging their profession into what they felt were premature applications. Fourth, Witmer had an unfortunate talent for antagonizing his colleagues (Reisman, 1976, p. 46). The responses to Witmer's talk also foreshadowed the conflicts that would arise between psychology as a science and psychology as an applied profession, some of which continue today.

At the same time, five aspects of Witmer's new clinic established the format that clinical psychologists would follow for about the next 40 years:

1. Most of his clients were children, a natural development since Witmer had been offering a course on child psychology, had published his first papers in the journal *Pediatrics*, and had attracted the attention of teachers who were concerned about their students' personal and academic problems.

2. His recommendations for helping clients were preceded by diagnostic assessment.

3. He adopted a team approach that saw members of various professions consulting and collaborating on individual cases.

4. He emphasized the prevention of future problems through early diagnosis and treatment.

5. He emphasized that clinical psychology should be built on the principles that were being discovered in the broader field of psychological science.

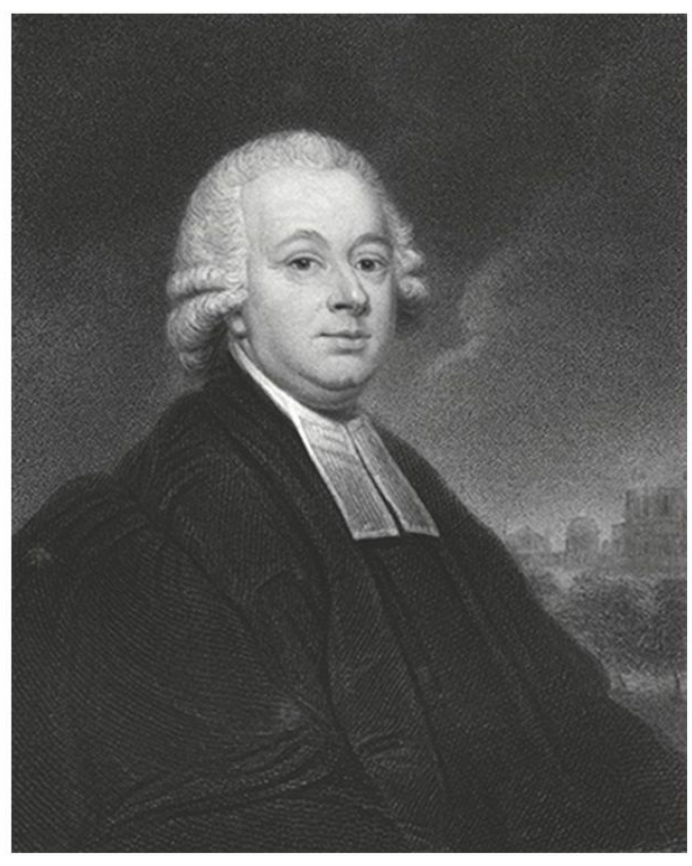
The last of these notions—that clinical practice should be built on solid scientific evidence—has remained at the core of clinical psychology, embodied now in the evidence-based practice movement described in Chapter 1. Fortunately, the scorn that Witmer endured at the hands of some experimental psychologists did not cause him to abandon his own training as a psychological scientist. As a result, the early history of clinical psychology, like the early history of psychology in general, is largely the history of experimental psychology (Boring, 1950). Other empirically trained psychologists eventually began to follow Witmer's lead by applying the results of various kinds of laboratory experiments to real-world problems in fields that became known as school psychology, counseling psychology, industrial/organizational psychology, consumer psychology, and the like (Benjamin & Baker, 2004).

Although Witmer got clinical psychology rolling, he had little to do with steering it. He lost influence largely because he ignored developments that would later become central to the field. For instance, in assessing children, Witmer failed to make much use of the new intelligence tests that we describe in Chapter 5. This decision was costly because intelligence testing came to characterize applied psychology perhaps more than any other activity during the first half of the 20th century (Benjamin & Baker, 2004). Witmer also had little interest in the early forms of adult psychotherapy that would come to dominate the field and define clinical psychology in the eyes of the public. Instead, he focused mainly on psychological problems that have since become more strongly associated with school psychology, vocational counseling, speech therapy, and remedial education than with clinical psychology (Fagan, 1996). In short, Witmer's contributions were significant, but do not by themselves explain clinical psychology's ultimate growth and diversity. To understand that part of the story, we must look elsewhere.

The Psychometric Tradition

A second source of clinical psychology’s development lies in efforts to measure individual differences in people’s physical and mental abilities. By “individual differences,” we mean differing levels of attributes such as extraversion, intelligence, or anxiety, that distinguish one person from another. The importance of examining these differences has been recognized for centuries. Four thousand years ago, prospective government employees in China were given calligraphy tests before being hired. In his *Republic*, the ancient Greek philosopher Plato suggested that prospective soldiers be tested for military ability before being accepted in the army, and Pythagoras, another Greek philosopher whose name you probably associate with right triangles, selected members of his brotherhood on the basis of their facial characteristics, apparent intelligence, and emotionality (DuBois, 1970; McReynolds, 1975).

More scientific measurements of individual differences did not occur, though, until the 18th century, and they appeared in the fields of astronomy, anatomy, and biology. The astronomical story began in 1796, when Nevil Maskelyne was Astronomer Royal at the Greenwich (England) Observatory. Part of his work required recording the moment at which various stars and planets crossed a certain point in the sky. His assistant, David Kinnebrook, made the same recordings at the same time, but Kinnebrook’s data always differed by five- to eight-tenths of a second. Maskelyne assumed that his own readings were correct and that his assistant was incompetent. As a result, Kinnebrook lost his job.



Nevile Maskelyne (1732–1811)
Analysis of the kinds of "errors" that got David Kinnebrook fired helped to launch the modern scientific study of individual differences. Here is a photograph of Kinnebrook's boss, but there are apparently no pictures of the man who was later called an "unconscious martyr to science." (For more details about him, see Rowe, 1983, and visit the History section of the website of the Royal Observatory Greenwich.)

(Source: Print Collector/Hulton Archive/Getty Images.)

This incident drew the attention of F. W. Bessel, an astronomer at the University of Konigsberg (Germany) observatory. Bessel wondered whether Kinnebrook's "error" might reflect something about the characteristics of various observers, and over the next several years, he compared his own observations with those of other experienced astronomers. Bessel found that

discrepancies appeared often and that the size of the differences depended upon the person with whom he compared notes. The differences associated with each observer became known as the “personal equation,” because they allowed calculations to be corrected for personal characteristics. Bessel’s work led to research by psychologists on the speed of, and individual differences in, reaction time and contributed indirectly to the growth of current research on the psychology of cognitive biases (Canales, 2001).

Interest in individual differences can also be seen in the early 19th-century work of German neuroanatomist Franz Gall and his pupil Johann Spurzheim. As a young man, Gall thought he saw a relationship between his schoolmates’ mental characteristics and the shapes of their heads. This notion later led Gall to promote *phrenology* (see Figure 2.1), the idea that each area of the brain is associated with a different “faculty” or function (self-esteem, kindness, or religiosity, for example). It was said that the better developed each of these areas is, the more strongly that faculty will appear in a person’s behavior. Further, it was assumed that the pattern of over- or underdevelopment of each faculty could be seen in corresponding bumps or depressions in the skull above each area (Gall, 1835). Gall traveled throughout Europe measuring the bumps on people’s heads, beginning with prisoners and mental patients whose behavioral characteristics seemed well established (he thought the “acquisitiveness” bump was especially strong among pickpockets). Later, he studied people from other segments of society, and with Spurzheim’s help eventually created a map of the brain’s 27 “powers” or “organs.” Phrenology was wildly popular with the general public who gladly paid Gall and other phrenologists to “have their head examined” (now you know where that phrase comes from) and to get a written profile describing their mental makeup (Benjamin & Baker, 2004).

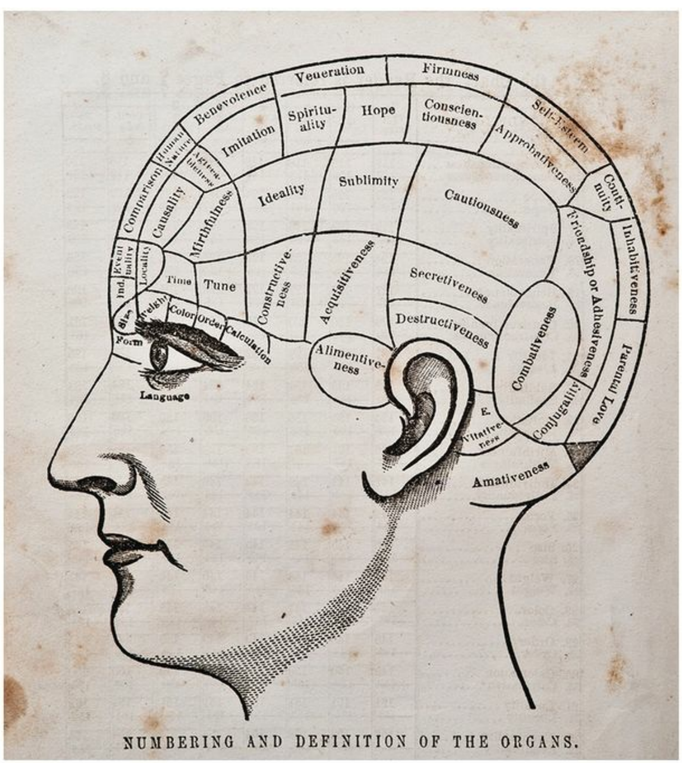


Figure 2.1 A Phrenological Map

A few of Franz Gall's ideas turned out to be correct, but the fact that most of his theory was wrong serves to remind us of the hazards of building theories solely on informal observation. Like most scientists, Gall wanted to be right, so rather than looking for evidence that might disconfirm his theory, he focused on evidence that seemed to confirm his beliefs and expectations. This widespread human tendency is known as *confirmation bias* (Faigman, 2008; Mendel et al., 2011).

(Source: VintageMedStock/Archive Photos/Getty Images.)

Later research in neuroscience has shown that Gall was partly right, but mostly wrong. He was correct in saying that different brain areas are involved in particular functions, such as vision, movement, and language (Eling, Finger, & Whitaker, 2017). However, Gall's claims about the nature and

location of brain functions and about the meaning of the skull's contours were recognized—even by the scientists of his day—as spectacularly wrong. Gall was also wrong in thinking that complex psychological processes, such as love or aggressiveness, are associated with activity in just one specific brain area.

Individual differences were also central to Charles Darwin's momentous work, *Origin of Species*, published in 1859. In it, Darwin proposed two important ideas: that (a) variation of individual characteristics occurs within and between species (including humans); and (b) natural selection takes place in part on the basis of those characteristics. His cousin, Sir Francis Galton, was fascinated by these ideas, and quickly applied Darwin's notions to research on the inheritance of individual differences—especially in mental abilities. For example, Galton (1883) measured people's ability to make fine discriminations between objects of differing weight and between varying intensities of heat, cold, and pain. He also developed the word association test to explore mental connections people make between psychological concepts (he might ask, for example "What's the first thing that you think of when you hear the word 'mother'?"). Eventually, Galton set up the world's first mental testing center, where, for a small fee, anyone could take a battery of tests and receive a copy of the results. Galton's method of systematically collecting samples of behavior from large groups of people launched what came to be known as the *mental testing movement*.

The person usually credited with merging individual mental measurement with the new science of psychology was the American psychologist James McKeen Cattell who, like Witmer, had studied with Wundt. Cattell was one of the first psychologists to appreciate the practical usefulness of tests in the selection and diagnosis of people. His experience in

Wundt's laboratory taught him that "psychology cannot attain the certainty and exactness of the physical sciences unless it rests on a foundation of experiment and measurement" (Dennis, 1948, p. 347). With this principle in mind, in the late 1800s, Cattell constructed a standard battery of mental tests for use by researchers interested in individual differences. He chose 10 tests that reflected the then-prevalent tendency to use sensorimotor functioning (such as the ability to detect differences in the pitch of two similar sounds) as an index of mental capacity, and he tested people's performance under varying conditions. He also collected less systematic information about people's dreams, diseases, preferences, recreational activities, and plans (Shaffer & Lazarus, 1952).

Alfred Binet (pronounced "bee-nay"), a French lawyer and scientist, was another key figure in the mental testing movement. In 1896, Binet and his colleague Victor Henri developed a battery of mental tests for both typically developing children and those with intellectual disabilities. Their tests measured not just "simple part processes," such as space judgment, motor skills, muscular effort, and memory, but also comprehension, attention, suggestibility, aesthetic appreciation, and moral values. Binet's later work with Théodore Simon led to the development of the first formal intelligence test, the *Binet–Simon scale*. A revised, English language version of this test was introduced in the United States in 1916 by Lewis Terman of Stanford University. The popularity of this *Stanford–Binet Intelligence Test* grew so rapidly that it overshadowed all others, including those being used by Witmer. In spite of Binet's own warning that his test did not provide an objective and comprehensive measure of intelligence, most new university psychological clinics and institutions for intellectually disabled children and adults adopted Binet's approach. If he were alive today, Binet would surely

be dismayed by the extent to which people mistakenly assume that intelligence test scores reflect a fixed number that perfectly captures people's cognitive abilities.

By the early 1900s, psychologists were involved in measuring individual differences in mental functioning using two overlapping approaches: (a) the Galton–Cattell sensorimotor tests, aimed at assessing largely inherited, relatively fixed mental *structures*; and (b) the instruments of Binet and others, which emphasized complex mental *functions* that could be taught to some degree. Each of these approaches was important for the development of clinical psychology. The first influenced Witmer and helped establish the first psychological clinic. The second provided the mental tests that would allow early clinical psychologists to find their professional identity (Benjamin & Baker, 2004).

The Clinical Tradition

The third main source of clinical psychology's emergence and growth is the centuries-old desire to understand and change human behavior that appears bizarre, irrational, or otherwise disordered. Early explanations of what today we call psychopathology involved possession by demons or spirits, so treatment involved various forms of exorcism, as well as *trephining*, the boring of holes in the skull to provide evil spirits with an exit.

An Exorcism

This exorcism being performed in Singapore is designed to cast out the evil forces that are seen as causing this man's disorder. Supernatural explanations of mental disorder remain influential among religious groups in many cultures and subcultures around the world (Fountain, 2000; Paniagua, 2013). Awareness of this influence tends to increase following news reports of people dying during exorcism rituals (e.g., Christopher, 2003).

(Source: Roslan Rahman/AFP/Getty Images.)

In early monotheistic cultures, God or the devil were seen as possible sources of behavior problems. In the Old Testament, for example, we are told that "the Lord shall smite thee with madness, and blindness, and astonishment of heart" (Deuteronomy 28:28). Where supernatural approaches to behavior disorders were prevalent, philosophy and religion were dominant in explaining and dealing with them. Although they are not prominent in Western cultures today, supernatural—and especially demonological—explanations remain influential in other cultures around the world and in some ethnic and religious subcultures in North America.

Supernatural explanations of behavior disorders were still highly influential when, in about the 4th century BC, the Greek physician Hippocrates boldly proposed that these conditions stem from natural causes, not supernatural ones. Hippocrates argued that behavior disorders, like other behaviors, are influenced by the distribution of four bodily fluids, or *humors*: blood, black bile, yellow bile, and phlegm. We now recognize this theory as flawed. Still, it is generally acknowledged as the first **medical model** of psychopathology because it linked mental disorders to bodily functions; it paved the way for the concept of *mental illness* and legitimized the

involvement of the medical profession in its treatment. From the time of Hippocrates until the fall of Rome in AD 476, physicians supported and reinforced a physical, or medical, model of behavior disorder.

Medical model

The assumption that psychopathology is caused by malfunctions in biological systems.

The medical model was swept away during the Middle Ages as the church became the primary social and legal institution in Europe. Demonological explanations of behavior disorders regained prominence, and religious personnel again took over responsibility for dealing with cases of deviance. Many resourceful physicians adjusted to this situation by becoming priests and treating people labeled “insane” through exorcisms and other spiritual means.

As the Renaissance dawned in Europe around 1400, the pendulum gradually began to swing back to naturalistic explanations of mental illness. At first, the treatment of deviant individuals took the form of confinement in newly established hospitals and asylums, such as London’s St. Mary of Bethlehem, organized in 1547 and referred to by locals as “Bedlam” (a term that still refers to scenes of uproar and confusion). Feared and misunderstood by members of the general public—many of whom still saw mental disorder as a sign of demonic possession—asylum inmates were little more than

prisoners who lived under horrible conditions and received grossly inadequate care.

It was not until the late 18th and early 19th centuries that conceptions of mental illness began to change and European and North American reformers pushed for more humane treatments and living conditions. For example, Philippe Pinel, a French physician in charge of the Salpêtrière Hospital in Paris famously said, “It is my conviction that these mentally ill are intractable only because they are deprived of fresh air and liberty” (Zilboorg & Henry, 1941, p. 322). In the United States and Great Britain, efforts to improve the treatment of people with severe disorders paralleled those in France. Benjamin Rush, often regarded as the father of American psychiatry (Schneck, 1975), was instrumental in changing the way institutionalized mentally ill patients were treated in the United States. In Great Britain, William Tuke played a similar role. Both men had one foot in the nonscientific past—Rush, for instance, still advocated such antiquated treatments as bloodletting and an immobilizing “tranquilizer” chair, while Tuke favored the aptly named “whirling chair” and cold baths. But both also anticipated the future—they favored removing physical restraints (as Pinel had done), they sought to study mental illness scientifically, and they argued that mentally ill patients deserved respect and kindness. Other reformers such as Dorothea Lynde Dix, a New England schoolteacher, campaigned to improve mental hospital conditions, launched public information campaigns, lobbied legislative groups, and eventually played a role in founding more than 30 state institutions for people with mental illness (Schneck, 1975).

Thus began a new awareness of the possibility that people with psychological disorders could be helped rather than simply hidden, and it was physicians who assumed the responsibility for doing so. The role of

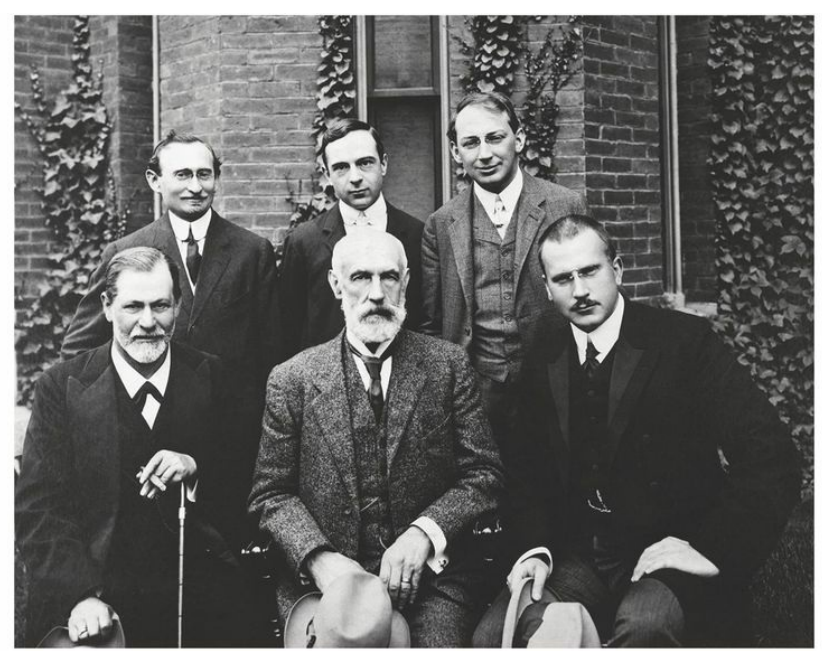
physicians in treating mental disorders was further solidified when, later in the 19th century, syphilis was identified as the cause of general paresis, a deteriorating brain syndrome that had once been considered a form of insanity. Finding an organic cause for this mental disorder bolstered the view that all forms of psychopathology stem from biological factors. The notion that there could be “no twisted thought without a twisted molecule” (Abood, 1960) triggered a psychiatric revolution in which medical doctors focused on finding the organic causes of—and the best physical treatments for—every type of mental disorder (Zilboorg & Henry, 1941).

It turns out that genetic, biochemical, neurological, and other biological factors do play a key role in most, if not all, mental disorders, but as you will see later in this chapter, we now know that these are not the only causes. These disorders are also influenced by a variety of cognitive, motivational, developmental, social, environmental, and cultural processes (Kendler, 2005). Today, it would be naïve to assume that every psychological disturbance is traceable to a single molecular dysfunction.

New ways of thinking about mental illness required new ways of categorizing it. In 1883, German psychiatrist Emil Kraepelin (pronounced “KRAY-plen”) proposed the first formal classification of mental disorders. He categorized disorders according to the specific patterns, or *syndromes,* of signs and symptoms that he saw as distinguishing various forms of disorder from each other. (*Signs* are observable indicators of disorder, such as incoherent speech, whereas *symptoms* are indicators, such as sadness, that can only be reported by clients themselves.) Kraepelin’s classification system also took into account the typical patterns of change seen in various disorders. For example, he noted that schizophrenia usually stays more or less constant over time, whereas manic depression (now called bipolar disorder),

tends to come and go in discrete episodes. Kraepelin's system itself is no longer used, but his approach—classifying mental illnesses in terms of signs, symptoms, and natural history—is still evident in the latest editions of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), and the *International Classification of Diseases* (ICD-11).

Eventually, the revolution that led medical doctors to see mental disorders as physical diseases also led some of them to think that disorders might have *psychological* causes, too. For example, in the mid-1800s, a French physician named Jean-Martin Charcot (pronounced "shar-KOH") found that hypnosis could alleviate certain behavior disorders, particularly hysteria (typically now diagnosed as conversion disorder). Charcot's lectures were well attended—among the regulars were Alfred Binet, American psychologist William James, French neurologist Pierre Janet (pronounced "jha-NAY"), and a young Viennese neurologist named Sigmund Freud. Janet came to believe that some parts of the personality could become split off or *dissociated* from the conscious self and produce symptoms such as paralysis. By 1896, Freud had proposed the first version of his own theory, which described mental disorders not as organic problems but as evidence of dynamic struggles within the mind to satisfy instinctual (mainly sexual) desires while also coping with the rules and restrictions of society. Because Freud did so much to develop and publish his theory (Watson, 1978), he became far better known than Janet. Freud's *psychodynamic* theories were introduced to North America during the 1890s partly through journal articles by William James (Korchin, 1976; Taylor, 2000), who had strong interests in the self, the ego, and "dissociated" states of consciousness such as trance, hypnosis, and unexplained memory loss.



Freud at Clark University, Worchester Massachusetts in 1909
Here is Sigmund Freud, at the far left in the front row next to G. Stanley Hall and Carl Jung, one of his earliest European followers. At the back are, from left, A. A. Brill, who would be the first to translate Freud's writings into English, Ernest Jones, who would become Freud's biographer, and Sándor Ferenczi, another of Freud's early followers. During this, his only visit to the United States, Freud received his one and only honorary university degree.

(Source: Bettmann/Getty Images.)

Freud's ideas were at first not well-received on either side of the Atlantic. One critic called them "a scientific fairy tale" (Krafft-Ebing, quoted in Reisman, 1976, p. 41). Nevertheless, in 1909, G. Stanley Hall, a psychologist who was president of Clark University at the time, invited Freud to give a series of lectures there (Hilgard, 1987). Freud's ideas eventually caught on and grew to become a comprehensive theory of the dynamic nature of behavior and behavior disorders and a detailed description of

psychological treatments for those disorders. So it was ideas from the clinical (medical) tradition that ultimately redirected the entire course of the mental health professions, including the one that would become clinical psychology.

The empirical, psychometric, and clinical traditions in clinical psychology provided a stable base for the field, much as three legs provide the stable base for a stool. Without all three, clinical psychology would probably have collapsed. With all three in place, it could grow and support future developments—which is exactly what happened.

In Review The Roots of Clinical Psychology

Landmarks of the Empirical Tradition in Clinical Psychology		
Dates	**Key Figures**	**Contributions**
Mid-1800s	Müller, Helmholtz, Weber, Fechner	Studied sensory discrimination and perception; explored and measured nerve impulses; sought explanations of mental events in terms of physical processes.
1879	Wundt	Established first laboratory designed specifically to study mental processes; trained many students who went on to establish psychology programs at universities in Europe and the United States.
1896	Witmer	Student of Wundt; established the first psychology clinic and the first journal devoted to clinical psychology; founded clinical psychology in the United States.
Landmarks of the Psychometric Tradition in Clinical Psychology		
Dates	**Key Figures**	**Contributions**
Late 1700s–1880s	Bessell, Gall, Galton	Noted individual differences in recording observations; measured physical and physiological reactions to assess personality and mental

		functioning.
1896	Binet	Developed a battery of tests to assess mental processes in children; administered tests to large numbers to develop norms.
1890s–early 1900s	Terman, Cattell	Helped to popularize Binet-style tests in the United States; founded psychology laboratories in the United States that emphasized measurement of individual differences.
Landmarks of the Clinical Tradition in Clinical Psychology		
Dates	**Key Figures**	**Contributions**
1880–1890s	Kraepelin, Charcot, Janet	Classified psychological disorders; studied and treated patients with atypical neurological symptoms (“dissociations”); used case studies of pathology to reveal general principles about healthy and unhealthy workings of the mind.
1890	James	Participated in both empirical and clinical traditions; helped introduce European psychology and psychiatry to U.S. audiences; wrote *The Principles of Psychology*, which some still regard as the most influential psychology book ever written.
1895–1939	Freud	Advanced a psychodynamic view of

		personality, disorder, and psychotherapy; his approach came to dominate psychiatry and clinical psychology in the United States during the first half of the 20th century.

Test Yourself

1. The clients first seen at Witmer's psychological clinic were all _________.

2. Some of the earliest attempts to scientifically measure individual differences among people occurred in the field of _________.

3. One of the earliest proponents of more humane treatment of hospitalized mentally ill patients was a French physician named _____________.

You can find the answers in the Answer Key at the end of the book.

Clinical Psychology Begins to Grow

Section Preview In this section, you will see that, with its roots well established, clinical psychology began to grow during the first four decades of the 20th century. Opportunities for application expanded, first in psychological testing and later in psychotherapy. Psychologists created professional organizations to support practitioners and establish guidelines for the field. Much of the accelerating growth of clinical psychology can be traced to the changing needs of society during and after World Wars I and II.

By the early 1900s, psychology departments had been established at many universities in North America and Europe, and the faculty in those departments had begun to apply psychological knowledge through direct service to the public. There were 20 psychological clinics on university campuses by 1914 (Watson, 1953). Many of them were created in the image of Witmer's clinic, but the emphasis gradually shifted from testing and treating children with academic difficulties to testing and treating children with other kinds of problems, and then to testing and treating troubled adolescents and adults.

Psychological Testing Expands

Because of its emphasis on careful measurement and standardized administration, psychological testing had the respect of many early empirical psychologists. Compared to psychotherapy, testing was considered to be a more rigorous, "hardheaded" application of psychology. As psychologists began to find work in mental hospitals, clinics, and specialized facilities for people with physical and/or intellectual disabilities, their testing contributions became more widely accepted by psychiatrists and other members of the medical community. Those contributions were particularly noticeable during staff meetings at which individual cases were discussed (Benjamin & Baker, 2004).

For much of the first two decades of the 20th century, psychological testing largely involved intelligence testing, but with psychologists now working in a wide range of adult and child facilities, the need for a broader range of tests and more "mental testers" became clear. This need was dramatically amplified in 1917, as the United States prepared to enter World War I. Large numbers of military recruits had to be classified in terms of both intellectual ability and psychological stability. There were no group techniques available for that kind of testing, so the U.S. Army asked Robert Yerkes (then president of the American Psychological Association) to form a committee of assessment-oriented experimental psychologists whose task it would be to develop appropriate test instruments. The committee produced a pair of group-administered measures of mental abilities, called the *Army Alpha* and *Army Beta* intelligence tests. The first was used with recruits who could read; the second with those who could not. To identify recruits with

psychological disorders, the committee recommended using Robert Woodworth's *Psychoneurotic Inventory* (discreetly retitled as "Personal Data Sheet"; Yerkes, 1921, in Dennis, 1948). By 1918, psychologists had tested nearly 2 million men.

The 1920s and 1930s saw the development of many new tests of intelligence, personality, interests, specific abilities, emotions, and other individual characteristics (we describe some of these tests in Chapter 5). Among the most prominent were Carl Jung's Word Association Test (1919), the Rorschach Inkblot Test (1921), the Miller Analogies Test (1926), the Goodenough Draw-A-Man Test (1926), the Strong Vocational Interest Test (1927), the Thematic Apperception Test (TAT) (1935), the Bender–Gestalt Test (1938), and the Wechsler–Bellevue Intelligence Scale (1939). Testing became so popular after World War I that there were complaints from some quarters that academic conferences were being overrun by psychologists describing their newest mental tests (Benjamin, 1997; Benjamin & Baker, 2004). When the number of published psychological tests passed the 500 mark in the late 1930s, a *Mental Measurements Yearbook* was needed just to describe, classify, and evaluate them (Buros, 1938; see Figure 2.2).

Figure 2.2 The Tests Just Keep on Coming

Try this Though not actually published every year, the latest edition of the Mental Measurements Yearbook contains information and critical reviews

on more than 3000 tests, alphabetized from the Adaptive Behavior Scale to the Zip Scale for Determining Independent Reading Level (Carlson, Geisinger, & Jonson, 2017). Take a minute to visit the website of the Buros Mental Measurement Yearbooks to get an idea of the impressive range of tests available to clinicians today. Perhaps you have taken one or more of them yourself.

Clinicians Become Psychotherapists

With many clinical psychologists already working in settings other than child guidance clinics in the early part of the 20th century, their role as therapists evolved as a natural extension of their diagnostic and remedial services. Still, the idea of clinicians providing psychotherapy was not immediately supported by the psychiatric community, or by some psychologists. Remember that psychology began as an academic, laboratory-based discipline, and was at first applied mainly in the realm of testing children, so relatively few early clinicians were interested in psychotherapy, especially with adults. Many, including Witmer, were quite skeptical about the appropriateness of this expanded role (Benjamin & Baker, 2004; Taylor, 2000). Interest and acceptance slowly grew, though, because: (a) psychological testing had already expanded to include measures of personality and psychopathology; (b) many of the child guidance clinics where clinical psychologists worked had broadened their client base to include treatment of social as well as educational maladjustment; and (c) as English translations of Freud's theories began to appear after 1909, more and more clinicians wanted to learn about his psychoanalytic treatment methods.

At first, opportunities for training in psychotherapy were hard to come by, mainly because training in any aspect of clinical psychology was scarce. University psychology departments were dominated by faculty who were steeped in Wundt's empirical tradition, and thus questioned the appropriateness of spending time, money, and teaching positions on "applied" training programs like clinical psychology. Many also criticized what they saw as the imprecise and unscientific nature of Freud's theories.

So, with few exceptions, formal training in psychotherapy—which at that time meant psychoanalysis—was available only from psychoanalytic institutes and medical schools. Most of those institutions were run by faculty who thought that the right to offer psychotherapy should be restricted to physicians—and psychiatrists, in particular (Abt, 1992; Benjamin & Baker, 2004; Schneck, 1975). These restrictions were ironic, because Freud had made it clear that he hoped to spread the gospel of psychoanalytic theory and therapy to all mental health professionals.

As a result, psychotherapy did not become a major activity for clinical psychologists until the end of World War II. The need for psychological testing services during World War II was even greater than in World War I, as was the need to treat military personnel who had experienced combat-related trauma. Many military family members and others who suffered stress-related disorders on the home-front also needed psychological help. Psychologists who had any amount of clinical training were recruited in large numbers to help meet these needs in hospitals and clinics, where they worked side by side with psychiatrists and social workers. It was in this arena that these clinicians began to learn and apply psychoanalysis and other variations on Freud's psychotherapy techniques (Cautin, 2011). After the war, many of them wanted to continue to work as psychotherapists, and a series of U.S. government initiatives dramatically increased their ability to do so.

One of the most important of these initiatives came from the Veteran's Administration (VA), now the U.S. Department of Veteran's Affairs. In 1946, the VA began to support training in the mental health disciplines. First, it made clinical internships available to clinical psychology trainees in its hospitals and clinics, where they provided psychotherapy to adult clients with a variety of disorders. Later, as we describe in Chapter 15, the VA provided

grants to psychology departments that were willing to offer graduate training programs in clinical psychology.

A second government initiative began in 1955 in the form of a network of *Community Mental Health Clinics* throughout the United States. Sponsored by the U.S. Public Health Service and the newly formed National Institute of Mental Health, these clinics were created in response to growing concerns about unmet mental health needs, and remain to this day as one of America's largest government-led mental health efforts. Like VA facilities, some of these community mental health centers offered internships for clinical psychologists in training.

So, it was largely in response to pressing social needs that mental hospitals and psychiatric facilities, which had long been the exclusive training grounds for psychiatrists, began to open their doors to clinical psychologists (Abt, 1992). At the same time, and partly in response to those same needs, some university psychology departments and a few psychoanalytic institutes created clinical psychology training programs. This was an important development because prior to World War II, there were no such programs and no such thing as a license to practice clinical psychology. To get a job as a clinical psychologist back then, all you needed was a few courses in testing, abnormal psychology, and child development, and an "interest in people." But there were still no standards to specify the courses and other training experiences these new programs should include if graduates were to be officially designated as clinical psychologists. Those standards would emerge once clinicians came together in professional organizations.

Clinicians Form Professional Organizations

In medicine, law, and most other professions, decisions about the training and experience needed to practice are made by the leadership of their state and national organizations. These organizations usually publish training standards or guidelines, establish codes of ethical conduct, define professional boundaries, and work with state legislators to establish licensing laws.

The first national organization of psychologists in the United States, the *American Psychological Association* (APA), did not follow this pattern, at least not immediately. Established in 1892, its stated goal was to advance the science of psychology, and as we already mentioned, its leadership was dominated by researchers, most of whom disapproved of clinical psychology. The APA did appoint committees on clinical training during the 1920s and 1930s, but its involvement was half-hearted. For example, in 1935 the APA Committee on Standards of Training in Clinical Psychology suggested that a Ph.D. degree plus 1 year of supervised experience was necessary to become a clinical psychologist. After issuing its report, though, the committee disbanded and little came of its efforts.

With more and more psychologists becoming interested in applying psychological knowledge beyond the laboratory, it was inevitable that conflicts would arise between APA members who wanted the discipline to only be a basic, pure science and those who wanted it also to be an applied science (Benjamin, 1997). Some of those who favored applied approaches began to create organizations that they hoped would be more responsive to their interests and concerns. The first of these was the *American Association of Clinical Psychologists* (AACP), formed in 1917 by a small group of

clinicians that, 2 years later, became APA's first special interest division, the *Section of Clinical Psychology*. A second group, the *Association of Consulting Psychologists* (ACP) was formed in 1930, and by 1937 both groups had become part of a national organization called the *American Association for Applied Psychology* (AAAP). Its *Journal of Consulting Psychology* was founded that same year, and is still being published—by the APA—as the *Journal of Consulting and Clinical Psychology* (Benjamin & Baker, 2004).

Leta Stetter Hollingworth (1886–1939)
Leta Hollingworth, a member of the psychology faculty at Columbia University, was the only woman among the eight founders of the AACP. She was also one of the first clinicians to suggest the kind of practice-

focused graduate training that we see today in the Doctor of Psychology (Psy.D.) degree described in Chapters 1 and 15. In addition, she proposed creation of a national examining board for clinical psychology similar to the one described below (Benjamin & Baker, 2004; Donn, Routh, & Lunt, 2000).

(Source: The Drs. Nicholas and Dorothy Cummings Center for the History of Psychology, The University of Akron.)

By the late 1930s, the APA realized that psychology was becoming a discipline whose members had strong applied interests. Many of them had already joined various state and national associations of professional psychology, so rather than risk losing applied psychologists, the APA leadership decided to make room for them (Benjamin, 1997). In 1945, the APA's bylaws were changed to read as follows: "The object of the American Psychological Association shall be to advance psychology as a science, as a profession, and as a means of promoting human welfare" (Wolfle, 1946, p.3). The Association also reorganized into special interest groups, called divisions, and about twice as many members chose to affiliate with the division of clinical psychology (Division 12) as with any other (Benjamin, 1997).

Other steps taken by the APA and its members between the mid-1940s and the mid-1950s defined clinical psychology with a previously unknown degree of clarity. For example, beginning with Connecticut in 1945, states began passing licensing and certification laws for clinical psychologists. A year later, the *American Board of Examiners in Professional Psychology* (ABPP) was established to certify that clinicians holding a Ph.D. were fully qualified. In 1949, as mentioned in Chapter 1, participants at a conference in

Boulder, Colorado established a model for clinical training—the scientist–practitioner or “Boulder” model—that would dominate university graduate programs for decades, and in 1953, the APA published its first set of ethical guidelines for clinical psychologists.

In Chapter 15, you will find more details about how these events shaped modern clinical psychology. For now, just be aware that, by the middle of the 20th century, clinical psychology had become a firmly rooted and well-organized professional discipline that was poised for growth. And grow it did. The dramatic rise in APA membership after 1950, shown in Figure 2.3, was driven largely by the ever-increasing growth of clinical psychology over that same time period. By about 1970, APA members with professional interests outnumbered the academic researchers whose predecessors had founded the organization (Benjamin & Baker, 2004).

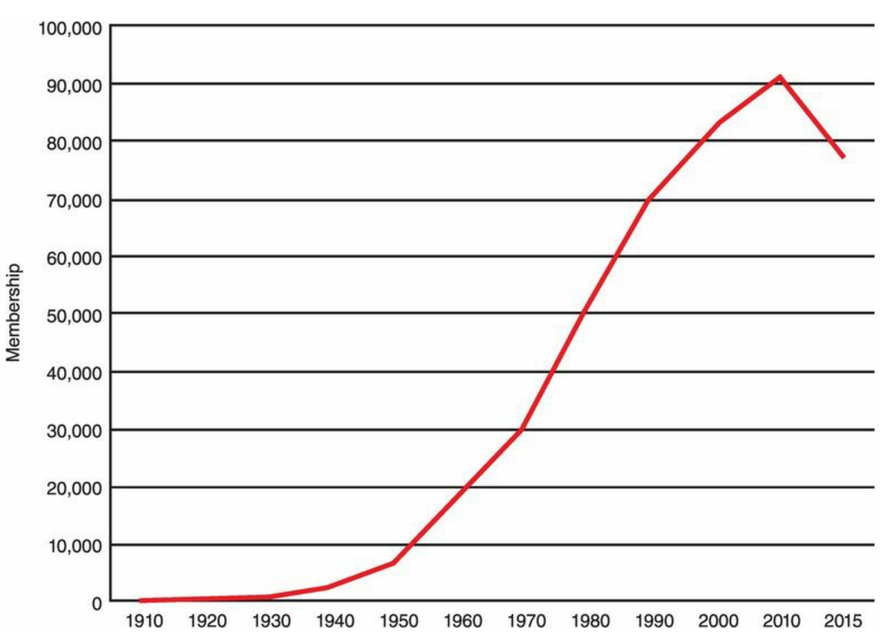


Figure 2.3 APA Membership 1910–2015

After languishing for decades, APA membership exploded after 1950, due mainly to the growth of clinical and other kinds of applied psychology. In

Chapter 15, we discuss some of the factors responsible for the recent reversal of that trend, including the growth of organizations such as the Association for Psychological Science.

(Source: American Psychological Association: Membership statistics. Retrieved September 21, 2018 from http://www.apa.org/about/apa/archives/membership.aspx)

In Review Clinical Psychology Begins to Grow

1900–1917	The number of psychological clinics grows and their services expand to include testing of children, adolescents, and adults. Clinicians begin to find jobs in a wider range of settings.
1917–1940	Clinicians participate in testing the intelligence and mental stability of World War I military recruits, begin administering a wider range of tests, and become more involved in treatment functions.
1940–1950	Clinicians' testing and treatment functions expand during and after World War II. The VA begins to support clinical training, the APA reorganizes to recognize clinical and other applied areas of psychology. Clinicians become better organized, set standards for training programs, and support state licensing laws.
1950 and beyond	Membership in the APA grows dramatically, due mainly to the ever-increasing number of clinical psychologists in its ranks. Clinicians' role as psychotherapists becomes well-established.

Test Yourself

1. Clinical psychologists could be licensed in certain U.S. states as early as _____.

2. The need for large-scale __________was one of the most important factors fueling the growth of clinical psychology in the first half of the 20th century.

3. The APA officially recognized its role in promoting applied psychology through a bylaw change in _______.

You can find the answers in the Answer Key at the end of the book.

Clinical Psychology Branches Out

Section Preview In this section, you will see that as the number of clinical psychologists grew after World War II, so too did the theories that became available to guide their work. At first, most clinicians adopted the psychodynamic approach that had dominated the field, but over time, humanistic, behavioral, cognitive, cognitive behavioral, social systems, and biological approaches began to compete for their attention. Because you have probably already taken courses in introductory, personality, and abnormal psychology, this section will merely review the basic assumptions and general features of these approaches to clinical assessment and treatment. In other chapters, we show how various approaches influence clinicians' research and practice.

The Psychodynamic Approach

As already mentioned, Sigmund Freud was extremely influential in guiding the theory and practice of psychiatry and clinical psychology at the beginning of the 20th century. His original psychoanalytic theory, and a set of variations on it, established the **psychodynamic approach** to personality, psychopathology, and psychotherapy that most early clinical psychologists adopted. We also mentioned that Freud's theory was founded on the idea that human behavior is derived from the constant struggle between the individual's desire to satisfy inborn sexual and aggressive instincts and the need to respect social rules and realities (Funder, 2001). To Freud, the human mind is a place where what the person *wants* to do (instincts, impulses) must somehow be adjusted in light of what the world says can or *should* be done (reason, norms, morality). When the conflict between these internal and external forces leads to anxiety, the person uses psychological defenses (such as repression) against it. If the anxiety becomes too intense, or the defense mechanisms fail, symptoms of psychological disorder can appear.

Psychodynamic approach
A view developed by Freud that emphasizes unconscious mental processes in explaining human thought, feelings, and behavior.

Freud used the terms *id*, *ego*, and *superego* to represent the three aspects of the mind that are often in conflict. The id reflects the unreasoning demands

of our basic impulses, the superego reflects the equally strong demands of our internalized sense of morality, and the ego seeks compromise in light of the limits imposed on us in the real world. Freud said that people do not consciously experience the nature of their conflicts, let alone understand where they come from (usually from childhood), because the conflicts occur in the unconscious regions of the mind. What people *are* aware of, and what others see, are maladaptive ways of behaving, feeling, and thinking.

The goal of treatment for clinicians who take a psychoanalytic approach is to discover the sources of their clients' symptoms. Freud compared his treatment method to archeology: the therapist searches for deeper meaning, uncovering the forgotten or buried (repressed) memories and unexpressed emotions that are presumed to lie beneath the symptoms of disorder. With the therapist's help, the client gradually becomes aware of how deeply rooted conflicts, pushed (not quite successfully) into the unconscious, have come to be expressed as maladaptive thoughts and actions. The promotion of this awareness, called *insight,* is central to psychoanalytic treatment (e.g., Jennissen et al., 2018). For Freud, effective therapy helps to make the unconscious conscious, allowing us to understand and gain control over previously inaccessible psychological forces.

Freud's Consulting Room

Try this During psychoanalytic sessions, Freud's patients lay on this couch while he sat in the chair behind them. (The couch is now on display at the Freud Museum in London. Take a break and visit it online at the website of the museum.)

(Source: Authenticated News/Staff/Archive Photos/Getty Images.)

In the years since Freud first proposed his psychoanalytic theories and developed his treatment methods, a number of his followers, and their followers, created variations on it that have served to guide the research, assessment, and therapy methods used by today's psychodynamically oriented clinical psychologists. As we describe in Chapter 8, for example, modern psychodynamic theories and therapies tend to: (a) see the ego as doing more than just being a "referee" between the id and the superego; (b) place greater emphasis on social and cultural factors—and less emphasis on sexual and aggressive impulses—in causing conflict; and (c), involve briefer programs of treatment in which therapists play a more active role and clients sit facing their therapists rather than lying on a couch. In addition, whereas Freud's psychoanalysis placed a great deal of emphasis on how early relationships with parents and other childhood experiences shape our sexuality and hence our personality, psychodynamic therapists tend to focus more on the role of current interpersonal conflicts and other life events. Psychodynamic theories remain influential among clinicians who were trained in this tradition, but they are considerably less attractive to those with a more scientific orientation. In Chapter 8, we consider some of the controversies surrounding this approach.

The Humanistic Approach

By the beginning of the 1930s, clinical psychologists had an alternative to the psychodynamic approach because the **humanistic approach** to personality, psychopathology, and psychotherapy was emerging. It described people not as arenas in which intrapsychic conflicts play themselves out, but as individuals with an innate drive toward personal growth, a tendency for *self-actualization*. According to this view, if all goes well, we can consciously guide ourselves toward realization of our full and unique human potential (Schneider & Längle, 2012). The humanistic approach further suggests that psychological disorders occur when a person's natural growth potential is blocked by distorted perceptions of reality or lack of awareness of true feelings. These blockages can be cleared and personal growth can continue, say humanistic theorists, through the *phenomenological* or *experiential therapies* described in Chapter 8 (see Figure 2.4).

Figure 2.4 What is Reality?

Try this Humanistic therapies are rooted in a philosophy known as *phenomenology*, which sees human behavior as determined by how we perceive the world, in other words, by what we experience as our own personal realities. Does this drawing show a young woman in a feathered hat or an old woman in a shawl? The drawing does not change, but your perceptual processes allow you to organize it in either of two different "realities." Can you experience both of them?

Humanistic approach
A view of behavior as controlled by the decisions that people make about their lives based on their perceptions of the world.

One of the most prominent advocates of humanistic psychology was Carl Rogers, an American psychologist who, like most others in the 1930s, had been trained in psychoanalysis. He soon began to question its value, though, partly because he disliked the idea of being a detached expert whose task is to dig into the past and "figure out" the client's problems. With phenomenology in mind, he saw it as vital to see the world from his clients' point of view, so he allowed them to decide what to talk about, and when (Raskin & Rogers, 2005). The following quote from 1946 describes how he saw his role:

> *The therapist must lay aside his preoccupation with diagnosis and his diagnostic shrewdness, must discard his tendency to make professional evaluations, must cease his endeavors to formulate an accurate prognosis, must give up the temptation subtly to guide the individual and must concentrate on one purpose only: that of providing deep understanding and acceptance of the attitudes consciously held at this moment by the client as he explores step by step into the dangerous areas which he has been denying to consciousness.*
>
> (Rogers, 1946, pp. 420–421)

As he listened carefully to what his clients said, Rogers found recurring themes. He noticed, for example, that most people are so eager to gain the approval of their family, friends, supervisors, and others that they will do what is necessary to get it, even if it means thinking and acting in ways that are inconsistent, or *incongruent*, with the natural tendency to achieve their fullest human potential. The distortion of this *self-actualizing* tendency is especially likely when people experience what Rogers called *conditions of worth*—circumstances in which a person receives positive feedback from

others (and, ultimately, from themselves) only when they express certain approved behaviors, attitudes, and beliefs. Rogers saw conditions of worth as created early in life by parents, family, and teachers, but noted that people eventually adopt the approved thoughts and actions as their own. Of course, behaving to please others is part of a learning process that allows society to function, but Rogers pointed out that using external evaluations as one’s main compass can come at the expense of personal growth. People who face extreme or excessive conditions of worth are likely to be uncomfortable, and may display signs of psychological disorder.

The Behavioral Approach

The **behavioral approach** to clinical psychology began to attract attention in the mid-1950s, partly because it differed so much from the psychodynamic and humanistic approaches. This approach is based on the idea that our personalities and the psychological problems that we may have are a reflection of environmental influences that have shaped how we have *learned* to behave. Further, behaviorally oriented clinicians argue that undesirable actions can be changed through treatments—like those described in Chapter 9—designed to help people learn new and more adaptive alternative patterns of behavior. The learning principles upon which the behavioral approach is based were developed early in the 20th century, but not by clinicians. They came instead from laboratory research on classical and operant conditioning in humans and animals conducted by Ivan Pavlov, B.F. Skinner, Edward Thorndike, and others (e.g., Pavlov, 1897/1902; Skinner, 1938; Thorndike, 1905).

Behavioral approach

A view based on the assumption that human behavior is determined mainly by what a person has learned in life, especially through rewards and punishments and observation.

By the 1920s, other psychologists became interested in studying the role of conditioning and other forms of learning in the development of

psychological problems, particularly anxiety. For example, John B. Watson and Rosalie Rayner described an experiment in which they used the principles of classical conditioning to teach a 9-month-old child known as "Little Albert" to fear a harmless laboratory rat (Watson & Rayner, 1920). Albert had previously shown no fear of the rat, but he was upset by sudden loud noises. Could Albert's fearful response to noise be associated with the sight of the rat? To find out, they showed Albert the rat and as soon as he began to reach for it, they struck a steel bar with a hammer. After several pairings of the rat and this loud noise, Albert became upset by the sight of the rat alone. Albert's fear was said to have persisted in less extreme form for at least a month afterward. There is doubt and debate about exactly how the experiment was done, whether it should have been done (it was clearly unethical by current standards), what its effects were, and what eventually happened to Little Albert (Digdon, Powell, & Harris, 2014; Harris, 1979; Powell et al., 2014).

There is no doubt, though, that the Watson and Rayner report stimulated others to use learning principles to guide research on, and treatment of, psychological disorders. One such person was Mary Cover Jones, a young Vasser College graduate who was about to start graduate training in psychology at Columbia University. After hearing Watson lecture about Little Albert, she wondered if conditioning could be used to eliminate rather than create anxiety, and by 1924 she had published two papers on reducing children's fears (Jones, 1924a, b). In one case, she used social *imitation* to help 3-year-old "Peter" conquer his fear of rabbits. "Each day Peter and three other children were brought to the laboratory for a play period. The other children were selected carefully because of their entirely fearless attitude toward the rabbit" (Jones, 1924b, p. 310). The fearless examples set by these

children helped Peter become more comfortable with the rabbit, but his treatment was interrupted by illness. When treatment resumed, it included *direct conditioning*, a procedure in which Peter was fed his favorite food in a room with a caged rabbit. At each session, some of which were attended by Peter's fearless friends, the rabbit was placed a little closer to him, and his fear eventually disappeared. He summed up the treatment results by announcing, "I like the rabbit."

Mary Cover Jones (1897–1987)

During her graduate training at Columbia University in the 1920s, Mary Cover Jones pioneered several learning-based techniques for reducing children's fears, but her contributions were not widely recognized until the 1960s, when the behavioral approach to clinical psychology had become more popular.

(Source: The Drs. Nicholas and Dorothy Cummings Center for the History of Psychology, The University of Akron.)

The cases of Albert and Peter encouraged the application of learning principles in the treatment of many other disorders. The 1920s and 1930s saw learning-based treatments for sexual disorders, substance abuse, and various anxiety-related conditions, but the term *behavior therapy* did not appear until 1953, in a paper that described the use of Skinner's operant conditioning principles to improve the functioning of schizophrenia patients (Lindsley, Skinner, & Solomon, 1953). In the years since then, learning principles have been applied widely in the development of numerous techniques for the assessment and treatment of psychological disorders, and has made the behavioral approach one of the most popular and influential guides for research and treatment in clinical psychology.

The Cognitive Approach

Despite its popularity, the behavioral approach to clinical psychology was seen by some as limited by its strict focus on observable behaviors when describing personality and psychological disorders, and when evaluating treatment outcomes. Critics were quick to point out that behavioral theories, and the clinicians who applied them, were ignoring the thoughts, or cognitions, that accompany behavior and behavior disorders, and in doing so were missing important aspects of human psychology. Cognitively oriented researchers and therapists argued, for example, that behavior is guided mainly by how people think, and especially by how they think about themselves at a conscious level. These thought patterns, they said, are an important aspect of personality, and because thoughts are so closely linked to emotions, they serve as key factors in the development of psychological disorders (Salovey & Singer, 1991).

Thus, the research and assessment methods used by clinical psychologists who take a **cognitive approach** focus on what and how clients are thinking, and their treatment methods focus on modifying maladaptive behavior by influencing what clients believe, assume, and expect about the world, what they say to themselves, and the cognitions that guide (or misguide) their efforts at problem-solving. The cognitive approach started attracting attention in the mid-1950s, in parallel with the behavioral approach that it rivaled. Julian Rotter and George Kelly were two of its earliest advocates. Rotter (1954, 1966) focused mainly on expectancies as dimensions of personality, while Kelly's (1955) *personal construct theory* bore clear implications for psychotherapy. Kelly's approach to clinical

psychology was, like Rotter’s, based on the assumption that behavior is determined by what people expect to happen, or as Kelly put it, by how they anticipate the world.

Cognitive approach

A view that focuses on and attempts to alter for the better clients’ maladaptive self-statements, expectations, assumptions and other problematic mental processes.

George Kelly (1905–1967)

According to Kelly’s theory of personal constructs, people act in

accordance with their unique expectations about the consequences of their behavior, and their major goal is to validate their personal constructs and thus make sense of the world as they perceive it. Kelly's *fixed-role therapy* is designed to give clients a chance to change personal constructs that are causing problems, and to adopt more functional new ones.

(Source: The Drs. Nicholas and Dorothy Cummings Center for the History of Psychology, The University of Akron.)

Kelly said that behavior disorders occur when a person develops inaccurate, oversimplified, or otherwise faulty constructs about social experiences. For example, someone who sees everything in life as either "good" or "bad" is going to experience problems, because not all events and people can be classified this way without distorting reality. So if a person decides that all college students, political activists, and foreigners are bad and that all children, doctors, and clergy are good, that person will be wrong at least part of the time. The person will also be seen by others as close-minded, prejudiced, and a poor judge of character. For such people, interpersonal relationships are likely to be stormy.

Albert Ellis (1962, 1973, 1993, 2011) was another important, and far more flamboyant, figure in the emergence of the cognitive approach to clinical psychology. Like Kelly, Ellis was a psychologist who saw disorders such as anxiety and depression arising from people's misguided beliefs and expectations about the world. He noted, for example, that it is irrational to believe that we have to be liked by everyone in order to be happy. The same goes, he said, for the belief that we must be good at most things to be worthwhile human beings. But he said that the clinical psychologist's task in therapy is not just to point out the irrational, unrealistic, self-defeating nature

of these beliefs, but to actively challenge them and push clients to learn and adopt more rational, logical, and less distressing ways of thinking. In Chapter 9, we describe Ellis's *rational-emotive therapy*, whose methods include the use of strong, direct communications aimed at persuading clients to give up the irrational ideas with which they indoctrinate themselves into misery.

We also describe in that chapter other, less confrontational forms of cognitive treatment, one of the most influential of which is Aaron Beck's *cognitive therapy* (Beck, 1976, Beck & Dozois, 2011). It is based on the idea that certain psychological problems—especially those related to depression and anxiety—can be traced partly to involuntary thoughts and beliefs about the world that lead people to be self-critical and regularly interpret situations in negative ways. These include *catastrophizing* (e.g., "If I fail my driver's test the first time, I'll never pass it, and that'll be the end of my social life"), *all-or-none thinking* (e.g., "Everyone ignores me"), and *personalization* (e.g., "I know those people are laughing at me"). Beck refers to these thinking patterns as *cognitive distortions* that occur so quickly and automatically that the client does not stop to consider whether such thoughts make sense or are helpful. In cognitive therapy, the therapist first helps the client learn to identify the cognitive distortions that precede psychological problems. These maladaptive thoughts and beliefs are then considered as hypotheses to be tested and, if found to be unreasonable or unhelpful, can more easily be replaced with more adaptive ones.

The Cognitive Behavioral Approach

When they first came on the scene, the behavioral and cognitive approaches to clinical psychology were clearly at odds: strict behaviorists rejected cognitions as unmeasurable "mentalistic" concepts, whereas cognitive clinicians saw the behavioral focus on observable behavior as oversimplified and incomplete. In the 1960s and 1970s, though, there were signs of a truce, and eventually a blending of the two approaches occurred (Mahoney, 1974). Behaviorally oriented clinicians began to acknowledge the importance of studying the cognitions associated with various disorders, and cognitively oriented clinicians began to recognize the need for developing and evaluating procedures to help clients practice translating cognitive changes into behavioral ones. Albert Ellis, for instance, understood the importance of focusing on specific behaviors, not just irrational beliefs, and he eventually changed the name of his treatment approach from rational-emotive therapy to *rational-emotive behavior therapy* (Ellis, 1993).

The blending of the behavioral and cognitive approaches to clinical psychology made sense, too, because both of them focus on assessing and treating clearly defined and specific aspects of human behavior and both emphasize the importance of conducting well-controlled research to evaluate their underlying theories, their assessment techniques, and their treatment methods. By the late 1980s, the two viewpoints had become the **cognitive behavioral approach** to clinical psychology. As you will see in chapters to come, this approach includes a family of clinical assessment tools as well as a set of treatment techniques known as *cognitive behavior therapy*, or *CBT*. These assessments and treatments benefit from the refinements that resulted

from the integration of behavioral and cognitive principles (Beck, 2011). The fact that behavior therapy associations around the world have added the term “cognitive” to their names (Reinecke & Freeman, 2003) and that virtually all textbooks in introductory, abnormal, and personality psychology now present the once-distinct cognitive and behavioral theories in combination testifies to the popularity, even dominance, of the cognitive behavioral approach to clinical psychology today.

Cognitive behavioral approach
A view which focuses on learning as the main influence on behavior and the thoughts that accompany it; its treatment methods seek to change the way clients think as well as behave.

Social Systems Approaches

The approaches to clinical psychology that we have presented so far focus on the assessment and treatment of individuals, but individuals are never *just* individuals operating in a vacuum. So no matter which approach clinical psychologists favor, they are keenly aware that their clients' behavior, and behavior problems, are partly a reflection of the clients' social and cultural environments. They know that whether clients are children, adolescents, or adults, they are participants in *social systems* such as romantic relationships, nuclear or extended families, classrooms, friendship networks, clubs, work groups, and the like. They live in neighborhoods and are part of various cultural groups; they have access to differing resources and educational or financial opportunities. All of these characteristics of clients' social systems dramatically influence the opportunities available to them, the barriers they will encounter when trying to meet their goals, and the way others will treat them. So even when assessing or treating individuals, competent clinicians always take into account the influence of social and cultural forces operating within these systems. For clinicians who adopt various **social systems approaches** to clinical psychology, however, the impact of sociocultural factors takes center stage. Social systems approaches are not necessarily linked to particular theories of personality, behavior, and psychopathology, or to particular treatment formats and methods. They are more accurately characterized by the clinician's sensitivity to the role of environmental factors, such as experiences of poverty or discrimination, in shaping the client's behavior, mental processes, willingness to seek treatment, and likelihood of responding well to it.

Social systems approach

A view which highlights the clients’ roles in various social networks and the resulting need to use assessment and treatment methods (such as group, family, or couples therapy) that take into account the social and cultural forces operating within those networks.

The Biological Approach

As its name implies, the **biological approach** to psychology in general is based on the assumption that behavior and mental processes are largely shaped by biological processes. Researchers use this approach to study the behavioral and psychological effects of hormones, genes, brain activity, and other biological variables. When studying memory, for example, these researchers might try to identify changes taking place in the brain as information is stored there. When studying thought processes, they use high-tech imaging tools to look for patterns of brain activity associated with, say, making quick decisions or reading a foreign language.

Biological approach
A view that behavior and mental processes are significantly shaped by biological processes.

Some clinical psychologists take a biological approach, too, because they recognize that—as is the case when studying any other kind of behavior—a full understanding of disordered behavior requires identifying the biological processes associated with it. These clinicians often work with psychiatrists and neuroscientists to conduct research on the genetic, hormonal, neuroanatomical, and neurophysiological characteristics of people with psychological disorders (e.g., McTeague et al., 2017; Vermeij, et al., 2018). They also try to identify genetic and other biological factors that might

increase clients' risk for developing disorders, predict the severity of those disorders, and forecast the likelihood of improvement following psychological and/or drug treatments (e.g., Colodro-Conde et al., 2018; Kambeitz et al., 2017; Luby et al., 2018).

Clinicians have learned that biological factors can influence psychological disorders in various ways. Sometimes, the influence is relatively direct, as when alcohol or other drugs cause delirium or other brain syndromes, when degeneration of neurons in certain brain areas causes Alzheimer's disease, and when genetic abnormalities cause particular forms of intellectual disability. In most if not all cases, though, biological factors combine with psychological, social, and cultural ones in causing problems such as depressive, anxiety, personality, and schizophrenia spectrum disorders (Burke et al., 2016). These multiple causal pathways are included in *biopsychosocial* explanations of psychopathology, which try to take all of them into account (e.g., Kendler et al., 2011).

So even if they do not explicitly adopt a biological approach to clinical psychology, most clinical researchers and therapists today include biological factors in their explanations of psychological disorders and in their assessments of individual clients. They recognize, for example, that a person's genetic background, nervous system functioning, learning experiences, and sociocultural values can combine to create a predisposition, or *diathesis* (pronounced "dye-ATH-uh-sis"), for psychological disorders. Whether the person eventually displays symptoms of disorder is seen to depend both on the strength of the diathesis and on the kind and amount of stress the person encounters (Harkness, Hayden, & Lopez-Duran, 2015; Roisman et al., 2012). For example, a person may have inherited a biological vulnerability to depression or may have learned depressing patterns of

thinking, but these predispositions might not result in a depressive disorder unless the person is faced with a severe financial crisis or suffers the loss of a loved one. If major stressors don't occur, or if the person has good stress-coping skills, depressive symptoms might never appear or may be relatively mild (Canli et al., 2006). According to the **diathesis–stress model**, then, biological, psychological, and sociocultural factors can predispose us toward a disorder, but it takes a certain type or amount of stress to actually trigger it (see Figure 2.5). Another way to think about the diathesis–stress model is in terms of risk: The more risk factors for a disorder a person has—whether they take the form of genetic tendencies, personality traits, cultural traditions, or stressful life events—the more likely it is that the person will display a form of psychological disorder associated with those risk factors.

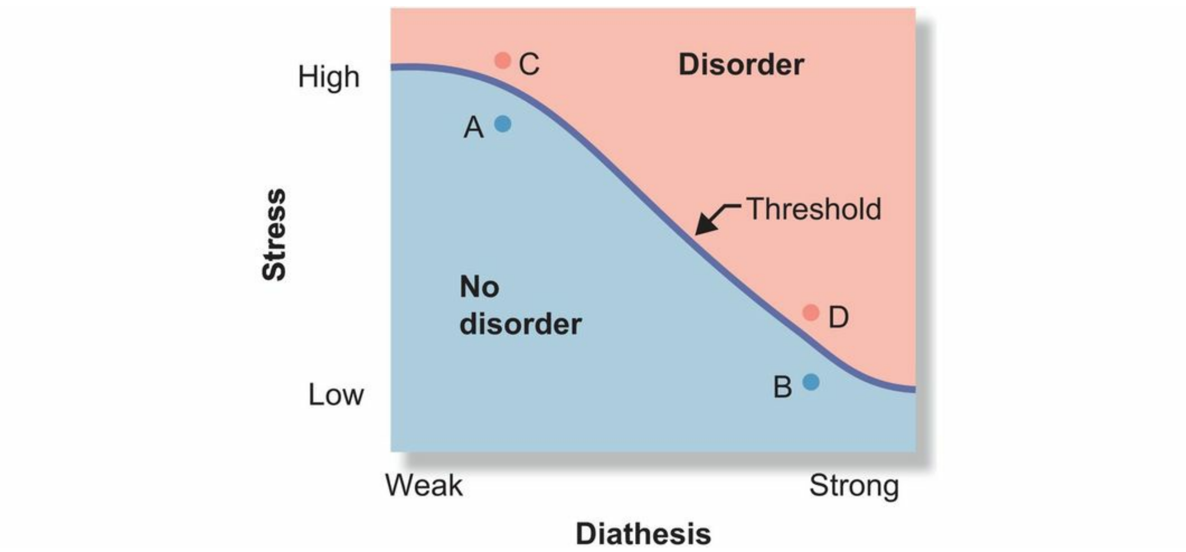


Figure 2.5 Diathesis, Stress, and Disorder

Diathesis–stress explanations suggest that psychological disorders can result from many combinations of predisposition and stress. Point D shows disorder stemming from a strong predisposition and relatively little stress. At Point C, disorder resulted from a weak predisposition but a lot of stress.

Points A and B represent blends of diathesis and stress that are not potent enough to trigger disorder.

(Source: Bernstein, D. A. (2019). *Essentials of psychology* (7th ed.), p. 454. Belmont, CA: Wadsworth Cengage Learning)

Diathesis–stress model
The idea that psychopathology stems from a sufficiently potent mixture of predisposition for disorder and life stressors.

Textbooks on abnormal psychology provide more detailed coverage of biological factors in psychological disorders, and the biopsychosocial and diathesis–stress perspectives used to explain them (e.g., Burke et al., 2016). In later chapters of this book, you will also see the impact of biological factors in clinical assessment and treatment.

Comparing Approaches: The Case of Rachel Jackson

Our description of the various approaches to clinical psychology might have left you wondering if perhaps clinicians offer psychodynamic treatment to clients with unconscious conflicts, classical conditioning programs to clients with phobias, cognitive behavior therapy for depressed clients, and humanistic therapy for those whose personal growth has stalled. The short answer is no. As you will see in the next section, most clinical psychologists are influenced to some extent by more than one approach, but they tend to emphasize a particular one in their research, assessment, and treatment activities. As an example of how various approaches might be applied in a given case, let's return to Rachel Jackson, the 17-year-old high school student whom you met at the beginning of Chapter 1. Recall that Rachel's worried mother told a clinical psychologist, Dr. Leon, about Rachel's questionable new peer group, her drug use, her crash dieting, and her plummeting grades. Shortly afterward, Rachel agreed, somewhat reluctantly, to meet with Dr. Leon, and during that session she described a number of other difficulties, including sadness over a recent breakup with her boyfriend and worries about being accepted by her new peer group that have led to difficulty sleeping, feelings of depression, and occasional thoughts of suicide.

Following an interview like that, all clinicians would recognize the potential seriousness of Rachel's situation, and would probably think about it within a diathesis–stress framework. Their assessment efforts would include gathering information to try to ensure her safety, including checking for any potentially dangerous medications that might have been prescribed for her, or are available to her, whether there are firearms in the home, and the like.

They would also want to know about any genetic and constitutional risk factors that may have created in Rachel a predisposition toward anxiety, depression, and substance abuse. The fact that both her parents have shown signs of depression would be of particular interest, as would any history of, say, alcoholism in the extended family. Assessment would also focus on identifying the social, economic, and other stressors in Rachel's life that may have triggered the kinds of problems to which she might be particularly vulnerable. But even clinicians who share the same general diathesis–stress view of Rachel's problems are likely to adopt considerably different causal explanations, diagnostic/assessment methods, and treatment techniques—all depending on their preferred approach to clinical psychology.

Psychodynamically oriented clinicians would probably speculate about conscious and unconscious conflicts that motivate Rachel's behavior, and perhaps employ one or more of the projective tests described in Chapter 5 to help reveal them. They might use free association, dream analysis, and other therapy techniques described in Chapter 8 to help Rachel become aware of these conflicts and of the psychological defenses, including crash dieting, that she may be using against them. They might also want to help her understand how the nature of her childhood relationships, especially her attachment to her parents, has created an exaggerated need to please others and be accepted.

Humanistically oriented clinicians would focus on helping Rachel to become aware of how conditions of worth, both in her family and in her peer group, may have led her to behave in ways designed mainly to gain approval, though at the cost of distorting her genuine feelings and impairing her personal growth. They would try to help her become more accepting of herself as she is, not just as others want her to be. Her parents and siblings might also be invited for family therapy sessions during which Rachel (and

the others) would have an opportunity to become aware of and express previously unexpressed feelings.

Behaviorally oriented clinicians might help Rachel learn to recognize the social situations in which she feels most anxious and to practice dealing with those situations in ways that allow her to manage her anxiety well enough as to no longer feel compelled to avoid or escape them. These anxiety management methods might include relaxation and assertiveness skills. Therapy might also include role-playing sessions in which she can practice effective ways of refusing drugs or dealing with snide remarks about her weight. It might also include development of an eating plan that would maintain a reasonable weight and help her set up suitable ways to reward herself for sticking to that plan. To improve her sad mood, Rachel might also be encouraged to schedule activities that will offer her more and different sources of reward from her environment. Rachel's parents might be asked to participate in treatment sessions aimed at reaching mutually acceptable rules regarding Rachel's curfew, studying times, household responsibilities, and other matters that might have been creating stressful conflicts at home.

Cognitive behavioral clinicians would supplement the behavioral approach by including efforts in their therapy sessions to help Rachel identify and re-evaluate some of her self-defeating thoughts or dysfunctional beliefs and assumptions (e.g., "I have to be liked in order to be happy," "I can't allow myself to fail," "My social worth depends on my appearance," "No one would like the real me"). She would be encouraged to focus on these thoughts as they occur, to identify the situations in which they are most likely, and develop and practice more reasonable and adaptive responses to her own unhelpful thoughts, such as "No one can be liked by everyone," and "I'm a valuable person even if X doesn't think so". Here again, family

members would probably be included in some treatment sessions, partly to help them learn how to better support and encourage Rachel's sense of self-worth.

Family sessions would surely be scheduled by clinicians who take a social systems approach, because they would want to focus specifically on how family dynamics influence Rachel's problems. Are there conflicts within the family that are overt or festering under the surface, and if so, are Rachel's symptoms reactions to these broader problems that she cannot fully understand or fix? How do other family members interact with Rachel, and she with them? Can roles, expectations, or communication patterns be altered to relieve Rachel, or others in the family, of burdens and help create more supportive relationships? In other words, clinicians who emphasize the importance of social systems would look at "Rachel's problems" as the family's problems.

The underlying assumptions and assessment and treatment methods associated with each approach to clinical psychology are presented in much more detail in later chapters. Our coverage here is meant only to make you aware that each of these approaches can be used with virtually any client and virtually any type of psychological disorder.

In Review Clinical Psychology Branches Out

Approach	Basic Features
Psychoanalytic/psychodynamic	1. Human behavior is determined by impulses, desires, motives, and conflicts that are often out of awareness. 2. Psychological problems occur because clients unsuccessfully defend against, and unconsciously replay, internal conflicts experienced in childhood or later in relation to family, peers, and authority figures. 3. Treatment is aimed at revealing and resolving conflicts and improving ego functioning so as to help clients recognize and change the ways they have behaved in the past.
Humanistic	1. Human nature is essentially positive; clients can be understood only by seeing the world from their point of view. 2. Problems develop when people try to avoid experiencing emotions that are confusing or painful, thus causing them to become alienated from, and unaccepting of, their true selves. 3. Therapists treat clients as responsible individuals who are experts on their own experiences and who must ultimately make decisions about their lives.

	4. The therapeutic relationship itself is seen as the primary vehicle through which therapy achieves its benefits. The goal is to keep the focus on the client's immediate, moment-to-moment experiences in a supportive atmosphere of honesty and acceptance.
Behavioral	1. Human behavior is seen as learned through conditioning and observation of others. 2. Psychological problems are learned behaviors that occur in specific situations or classes of situations. 3. Behavior therapy focuses on changing environmental factors that had been maintaining learned maladaptive responses. 4. Treatment methods are based on laboratory research on learning and stresses collection of data to evaluate treatment effectiveness.
Cognitive/cognitive behavioral	1. Behavior develops through learning which is accompanied by expectations, assumptions, beliefs and other kinds of cognitions. 2. Individuals develop their own ways of understanding events, and those explanations affect how they feel and behave. 3. Psychological problems develop when people's beliefs are dysfunctional

	and motivate correspondingly dysfunctional actions. 4. Therapists engage clients in a rational examination of their beliefs, encouraging them to test their hypotheses, explore alternate beliefs, and practice applying new ways of thinking.
Social systems	1. Human behavior develops in, and is maintained by, social networks that can support functional behavior but can also lead to psychological disorders. 2. Treatment is aimed at altering dysfunctional social systems, not just influencing the behavior of an individual identified client.
Biological	1. Understanding disordered behavior requires attention to the biological factors and processes associated with it, including genetic, hormonal, neuroanatomical, and neurophysiological variables. 2. Biopsychosocial explanations of psychopathology take biological, psychological, social, and cultural factors into account. 3. According to the diathesis–stress model, biological, psychological, and sociocultural factors predispose people to disorder, but it takes stress to trigger it.

Test Yourself

1. Treatment methods that are based on, but modify, Freud’s psychoanalytic theories allow therapists to take a more _________ role during therapy sessions.

2. Humanistic treatment methods are based on the philosophical view known as ___________.

3. The case of “Little Albert” helped to launch the __________ approach to clinical psychology.

You can find the answers in the Answer Key at the end of the book.

Thinking Scientifically Is it Best to Choose a Single Approach to Clinical Psychology?

As described in the previous sections, each approach to clinical psychology provides clinicians with a different theoretical framework that can guide their thinking, their research, and their practice.

What am I being asked to believe?

Most clinicians say that taking a particular approach is beneficial to them. They argue, for example, that when trying to explain psychological disorders—whether in general or in a given case—having a single approach helps them narrow the vast range of possible causes to a more manageable set that can then be evaluated through research and applied in practice.

What kind of evidence is available to support the claim?

Evidence for the benefits of taking a particular approach comes largely from clinicians' experience-based perceptions, not systematic data. Clinicians who share the same approach are a bit like groups who speak a regional dialect. That dialect allows them to understand each other through a kind of efficient professional shorthand. It also leads them to develop assessment methods that provide data about the variables that interest their group, develop treatment techniques based on their shared explanatory theories of disorder, and conduct the kind of research they see as best for evaluating the effectiveness of those treatments.

Are there alternative ways to interpret the evidence, including those that my biases and preconceptions might have kept me from seeing?

One problem with speaking a regional dialect is that people from other regions may not fully understand you, or may misunderstand you. So, when clinicians who take different approaches have a professional conversation, they may think they are speaking the same language, but their differing dialects may lead to miscommunication. Worse yet, the dialect problem can leave them unaware of substantial areas of agreement that might appear if their differing vocabularies were properly translated.

Another problem that can be created by choosing a singular approach to clinical psychology is that, while the choice can act as a valuable compass and guide, it can also become a set of blinders. Some clinicians allow their favorite approach to so completely organize their thinking about behavior and mental processes that their

views become fossilized, leaving them rigid and closed to potentially valuable ideas associated with other approaches (Gold & Strickler, 2006). Theoretical approaches should guide us, not imprison us (Nickerson, 1998). Consider the story of a person with paranoid schizophrenia who had been repeatedly escaping from the psychiatric inpatient unit at a hospital. A staff psychiatrist's biological approach led him to address the problem through ever-increasing doses of antipsychotic medication, but the escapes continued. When a different clinician's more psychological approach led her to interview the patient, she discovered that his escapes were motivated by fear of calling his mother on "bugged" hospital phones. When he was allowed to use a nearby public phone, he stopped escaping (Rabasca, 1999).

The blinders associated with a particular approach are created partly because when newer approaches appear, they tend to define themselves as superior to older ones and thus to reject most or all the assumptions and methods of competing approaches. The training that clinical psychology graduate students receive can compound this problem if professors and clinical supervisors exaggerate the differences across approaches or show disdain for the ones they don't use. The graduates of such programs may automatically adopt, promote, and teach the approach they were taught without careful consideration of its strengths and weaknesses compared to those of alternative approaches. In short, one's approach to clinical psychology can morph from an asset to a liability if it creates a focus so narrow that other potentially valuable concepts and points of view

are overlooked. When this happens, clients are poorly served and the profession is diminished.

What additional evidence would help to evaluate the alternatives? Fortunately, most of the problems associated with taking a single approach to clinical psychology can be reduced by: (a) avoiding the overzealous commitment to it that fosters conceptual rigidity, behavioral inflexibility, and obscure jargon; and (b) evaluating that approach according to rigorous scientific methods and revising the approach when the data demand it. Understanding and appreciating other points of view can provide at least some insurance against a narrow-mindedness that can be detrimental to clinicians and clients alike. Science thrives on competition among alternative views (Popper, 1959), and clinical psychology is no exception.

It would also be valuable to have more evidence about how clinicians choose their approaches to clinical psychology. Freudians might suggest that unconscious motivation influences the choice, behaviorists might argue that we tend to choose the approach that was modeled for us by our mentors and that we find most rewarding, and humanistic psychologists might seek the answer in the perceived congruence between a particular approach and the self-concepts of those who adopt it. Research suggests that trainees' personality characteristics, worldview, and general cognitive style influence their choices (Buckman & Barker, 2010; Kaplan, 1964; Poznanski & McLennan, 2003), but the truth is that no one really knows why particular clinicians choose particular approaches.

We do know which ones are most popular, though. Among clinicians expressing a single preference, cognitive and cognitive behavioral approaches are named most often (Andersson & Asmundson, 2008; Hollon & DiGuiseppe, 2011). Psychodynamic approaches remain popular as well, though not to the extent that they were a few decades ago. Social systems and biological approaches are also attractive to many clinicians, but not all clinicians make only one choice. Many say that they do not confine themselves to a single approach (Norcross, Hedges, & Castle, 2002). Instead, they tend to adopt aspects of two or more approaches that they find valuable and personally satisfying, a position we describe in Chapter 1 as *eclectic* or *integrative*. Various surveys have found that anywhere from 33% to 67% of clinicians identify themselves as eclectic (Hollanders & McLeod, 1999; Norcross et al., 2002; Norcross, Karg, & Prochaska, 1997; Slife & Reber, 2001).

The advantages of carefully integrating multiple approaches are clear—clinicians who are open to a variety of approaches are more likely to avoid the conceptual blinders created by allegiance to just one. They are also in a better position to adjust their thinking and practice when research suggests that they should. But being eclectic is not easy because the various approaches to clinical psychology are so varied that it is difficult for trainees to gain in-depth knowledge of all of them, and the effort to do so might be more confusing than enlightening (Gastelum et al., 2011). Further, it's not always clear how to combine different approaches, as they can be inconsistent. For example, a psychoanalytic therapist treating Rachel Jackson's eating problems might focus on her early childhood experiences, whereas a

behavior therapist might be most interested in the factors that are currently reinforcing her problematic dieting. Even the time required to develop solid conceptual grounding in several theories can be prohibitive, meaning that few if any practicing clinicians or researchers have an encyclopedic knowledge of the full range of alternative views.

What conclusions are most reasonable given the kind of evidence available?

Much as the behavioral and cognitive approaches found common ground and eventually merged, many clinical psychologists and clinical psychology training programs today are looking for ways to integrate what various theoretical approaches have to offer, searching anew for common elements in the causes of disorders and in the effectiveness of treatments (often referred to as *principles of change*; Elliott et al., 2018; Hofmann & Hayes, 2019; Nolen-Hoeksema & Watkins, 2011). Some have even suggested that the era of traditional theoretical orientations—such as psychodynamic, humanistic, or behavioral—is coming to an end, and that a new unified, integrative approach is at hand (Melchert, 2011). But change is not easy, and integrative approaches are still very much works in progress (Goldfried, Glass, & Arnkoff, 2010; Wampold, Hollon, & Hill, 2010). The same is true of any scientific field—the confirmation bias that is characteristic of human thinking makes it difficult for all of us to recognize the shortcomings of our most beloved theories and to look beyond them to find better ways to understand and apply what others have learned. However, true clinical scientists are determined to

overcome these problems for the betterment of their research and their clients' welfare.

Looking Ahead

As you can see, the field of clinical psychology has changed a lot over the years, and the changes continue today. These changes pose challenges as well as opportunities. In this section, we offer a preview of five newly emerging trends in clinical psychology whose influence you will see throughout the rest of this book.

Mechanisms of Change and Transdiagnostic Approaches

As mentioned in Chapter 1, the movement toward empirically supported therapies (ESTs) focuses on identifying treatments, such as cognitive behavior therapy, that work best for specific conditions, such as major depressive disorder (Chambless & Ollendick, 2001). However, some critics say that this approach is inefficient because it requires clinicians to master a different package of therapeutic techniques for each specific disorder. They point out, too, that by focusing attention on matching specific techniques to specific disorders, the EST approach may lead clinicians to overlook the common *mechanisms of change* that may be operating in the treatment of many different disorders (Hofmann & Hayes, 2019; Rosen & Davison, 2003). For example, systematic exposure to anxiety-provoking stimuli can be an effective mechanism of change in many anxiety-related disorders, from phobias and panic disorder to obsessive-compulsive and posttraumatic stress disorders. You will see the growing emphasis on common change mechanisms in our chapters on psychotherapy, particularly when we describe *transdiagnostic approaches* to treatment. These approaches seek to promote the key principles of change that research shows to be operating in the successful treatment of many psychological disorders (Barlow et al., 2017; Marchette & Weisz, 2017).

The Burden of Mental Illness and the Science–Practice Gap

There are enormous unmet needs for mental health services in the United States (Kazdin, 2018; Layard & Clark, 2014; Teachman et al., 2019). For example, although about 20% of Americans meet the criteria for having a major mental disorder, just under half of them receive treatment (Mental Health America, 2018). The percentage who get effective treatment is even lower. Only about 10% of those with major depressive disorder, for instance, receive cognitive behavioral, behavioral, or interpersonal therapies, the ones whose effectiveness is supported by the best available scientific evidence (McKay & Lilienfeld, 2015). This is just one illustration of the *science–practice gap* in mental health services that we refer to throughout this book. It refers to the sizable divide between what research evidence says about effective treatments and what clinicians actually do in their day-to-day clinical practice (Tavris, 2014). It also refers to the gap between what clinicians have learned about which treatments are effective and feasible in the real world of clinical practice, and the idealized treatments that researchers are advocating on the basis of their controlled, laboratory-like clinical trials.

The burden of mental illness and the size of the two-way science–practice gap are even greater in many low-and middle-income countries outside North America. In India and China, for example, about 90% of people with major mental disorders are receiving inadequate care (Patel et al., 2016). The picture in many developing countries is even worse. Fortunately, there is evidence that many of the mechanisms of change underlying successful treatments for major depression and posttraumatic

stress disorder that work well in North America are also effective for clients in low- and middle-income countries (Singla et al., 2017). As discussed later, we still need much more information about the degree to which empirically supported treatments that were developed in Western cultures work elsewhere, how those treatments might have to be adapted to individuals from diverse sociocultural backgrounds, and perhaps most important, how to ensure that those who most need effective treatment will actually get it.

Mental Hospitals Versus Prisons and Jails

In the 1960s, federal and state governments in the United States began implementing a policy known as *deinstitutionalization*, in which patients were released from large psychiatric hospitals so that they could be treated in less restrictive environments, including outpatient community mental health centers. As a result, the number of people confined in psychiatric hospitals today is only about one-thirtieth of what it was 60 years ago (Carey, 2018). Unfortunately, as you will see in later chapters, many of these deinstitutionalized patients received inadequate care in their communities. Many dropped out of treatment, never to return, and now endure the dangers of homelessness on city streets or confinement in jails and prisons (Luhrmann, 2008). As a result, jails and prisons have become the principal institutions for people with mental illness (Roth, 2018): There are about 45,000 psychiatric patients living in mental hospitals and about 1.3 million —yes, you read that number correctly—behind bars (Frances, 2013).

These developments raise a difficult question: Should we cling to the dream of community-based treatment for people with serious mental disorders, or should we re-open or build more psychiatric hospitals where many or most of these people could be housed as they were when our pre-1960s model of mental health care was in force (Orlinsky, 2018; Sisti, Segal, & Emanuel, 2015)? This complex debate raises a host of scientific, social, and ethical issues, and clinical psychology is right in the middle of it.

The Changing Landscape of Clinical Practice

Just as the landscape of mental health care has changed substantially in recent decades, so too have the professional backgrounds of those who offer that care. As research evidence accumulated to show that one does not need a doctoral degree in clinical psychology to be an effective psychotherapist (Atkins & Christiansen, 2001), more and more of the professionals who deliver psychological treatment are sub-doctoral social workers, mental health counselors, and marriage and family therapists, rather than doctoral-level clinical psychologists (McFall, 2006). According to recent survey data, psychologists and psychiatrists provide 16% and 9% of mental health care, respectively; the numbers for mental health counselors and social workers are 37% and 29% (APA Center for Workforce Studies, 2014). In the coming decades, clinical psychologists will need to adjust to a world in which they are clearly in the minority among mental health service providers.

Adding to their challenge is the fact that the traditional one-to-one, face-to-face model of psychological treatment may be unsustainable. The pressing need to alleviate the burden of mental illness highlights the necessity of considering alternative treatment models in which therapy is delivered: (a) by closely supervised bachelor's-level paraprofessionals, (b) via empirically validated "apps" that are supplemented by occasional meetings with psychologists, (c) through the use of internet-based self-help instructional materials, (d) in group therapy formats, and so on (Kazdin & Blase, 2011). Implementing new approaches to mental health delivery creates a host of challenges, chief among them is how to ensure consistent quality of service. These challenges will have to be met, though, if we are to help the millions of

troubled people around the world who are receiving inadequate mental health care or no mental health care at all.

New Approaches to Diagnosing Psychological Disorders

As we mentioned earlier in this chapter, the diagnosis of psychological disorders by clinicians in the United States and elsewhere has long been guided by the classification systems inspired by Emile Kraepelin's work on the signs and symptoms of mental illness. These systems are found in the latest editions of the *Diagnostic and Statistical Manual* (DSM) of the American Psychiatric Association (DSM-5; American Psychiatric Association, 2013), and the *International Statistical Classification of Diseases and Related Health Problems* (ICD-11; World Health Organization, 2018a). Over the past decade in particular, however, there has been growing dissatisfaction with the traditional emphasis on basing diagnosis on signs and symptoms (Mayes & Horwitz, 2005). Critics see signs and symptoms as superficial evidence of the psychological and neural processes that underlie disorders, but do not provide information about the processes themselves (Kihlstrom, 2002). It is, they say, like relying on the presence of fever to classify medical conditions when, in fact, fever is merely a superficial sign of an underlying infection that could be anything from a common cold or the flu to malaria or meningitis. Similarly, signs and symptoms such as depressed mood or panic attacks might reflect any number of underlying psychological and biological processes.

With these criticisms in mind, clinical psychologists and psychiatrists are developing a number of alternative approaches to diagnosis. One of the most prominent of these is emerging from the *Research Domain Criteria* (RDoC), a large-scale project initiated by the National Institute of Mental Health. Harking back to the earliest medical models, it conceptualizes mental

disorders as brain diseases generated by disturbances in neural circuitry (Insel & Cuthbert, 2015). Proponents of the RDoC say that a proper system for classifying psychopathology should focus on identifying the disrupted systems in the brain and elsewhere that lead to the appearance of various psychological disorders. For example, many anxiety disorders, such as panic disorder, may reflect overactivity of brain-based threat systems, whereas many substance use disorders may reflect disruption in brain-based reward systems. This RDoC approach to diagnosis has itself been criticized by those who fault it for paying too little attention to non-biological influences on psychopathology, such as the social environment and early psychological development (Lilienfeld & Treadway, 2016).

Another prominent alternative diagnostic approach is called the *Hierarchical Taxonomy of Psychopathology* (HiTOP). Its advocates argue that mental disorders should be thought of as extreme versions of the general personality traits measured by some of the tests described in Chapter 3, such as introversion, neuroticism, and impulsivity (Kotov et al., 2017). From the HiTOP perspective, various forms of psychopathology arise when either very high or very low levels of personality traits combine in maladaptive ways. For example, alcohol-use disorder, formerly called alcoholism, may often be produced largely by high levels of anxiety combined with high levels of impulsivity.

The long-term impact of these alternative diagnostic approaches remains to be seen, and the same can be said about the impact of the other emerging trends described here. They are all playing a role in shaping the future of clinical psychology, though, so stay tuned for further discussion of them in the chapters to come.

Chapter Summary

Clinical psychology has grown rapidly since its birth in the late 19th century. Although it began primarily as a laboratory-based research discipline, clinical psychology soon grew into an applied one, first in Witmer's psychology clinic, then in psychological testing, and later in psychotherapy. World events, particularly the human service needs created by two World Wars, were especially important in contributing to the development of the field. Each of several theoretical approaches to clinical psychology emphasizes different explanations of how behavior and behavior disorders develop.

The *psychodynamic approach* is based on Sigmund Freud's psychoanalysis, which sees both normal and abnormal behavior as determined by intrapsychic processes, especially conflicts among id, ego, and superego, that have roots in childhood. The *humanistic approach* characterizes behavior as determined primarily by unique perceptions of the world as experienced by humans who are responsible for themselves and capable of changing themselves. Clinicians taking this approach try to see the world through their clients' eyes and help them reach self-actualization by encouraging their awareness of genuine feelings, wishes, and goals. The *behavioral approach* focuses on measurable behavior rather than inferred cognitive activity or personality traits, and emphasizes the principles of operant and classical conditioning and observational learning in explaining and treating psychological problems. In recent years, the behavioral approach has blended with the *cognitive approach*, which focuses on habitual, learned ways of thinking about events. The *cognitive behavioral approach* has

become one of the most popular in clinical psychology, particularly among clinical scientists, who favor the evidence-based practice standards described in Chapter 1. The *social systems approach* emphasizes the powerful influence of clients' interpersonal and external environments and focuses on changing the dynamics of those environments rather than just trying to change the initially identified client.

Most clinicians are also influenced by the *biological approach* to clinical psychology in the sense that they recognize that understanding disordered behavior requires attention not just to psychological and social processes, but also to genetics, nervous system activity, and other biological processes. Biopsychosocial explanations lead them to think of psychopathology within the framework of a *diathesis–stress model*, in which biological, psychological, and sociocultural factors are seen as creating a diathesis, or predisposition, for a disorder that will only be triggered if a sufficient amount of stress or other setting conditions occur.

Although some approaches to clinical psychology are more popular than others, none has a monopoly on describing and explaining behavior. Many clinicians therefore adopt elements of more than one approach in their daily work. Among the most prominent recent trends are those toward eclecticism and integration. Both emphasize the need to determine, through empirical evidence, which models of behavior disorder are the most useful, and which forms of therapy are most effective. Other important trends include the emergence of transdiagnostic views of psychological disorders, process-oriented, rather than theory-oriented therapies for treating them, and national and global efforts to relieve the burden of mental disorder in society, especially among disadvantaged populations.

3

Basic Features of Clinical Assessment, Classification, and Diagnosis

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Contents

An Outline of the Assessment Process

The Goals of Clinical Assessment

Factors Influencing the Choice of Assessment Instruments

Clinical Judgment and Decision-Making

Communicating Assessment Results

Ethical Considerations in Assessment

Chapter Preview

In this chapter, we offer an overview of clinical assessment, classification, and diagnosis. We outline the range of assessment options available to clinicians, then describe the typical goals of assessment: diagnosis, description, treatment planning, and prediction. We also introduce variables that affect a clinician's choices about how to conduct an assessment, including the purpose of the assessment, the clinician's theoretical views, the psychometric properties of available assessment instruments, and other contextual factors. We discuss the use of clinical judgment, focusing especially on the errors that clinicians strive to avoid. The results of clinical assessments ultimately must be communicated to clients and third parties, so we conclude by discussing the factors and formats associated with assessment reports.

A Clinical Case

In Chapter 1, we introduced you to Rachel Jackson, a 17-year-old high school student whose worried mother met with a guidance counselor about Rachel's drug use, crash dieting, and falling grades. As we mentioned in Chapter 2, the counselor arranged for Rachel to see clinical psychologist Cynthia Leon and at her first session with Dr. Leon, Rachel revealed numerous other difficulties, including a recent romantic breakup and worries about being accepted by her new peer group, all of which have led to disrupted sleep, feelings of depression, and occasional thoughts of suicide. (This information was consistent with a report from the guidance counselor that Rachel

appeared sullen, irritable, and depressed in class and had been overheard telling a classmate that “I can’t take this anymore.”) She also admitted to skipping school, abusing numerous substances with her friends, and getting in trouble with teachers for misbehavior in class and attempting to cheat on a history exam. All these problems, she said, got worse after her father lost his job and her parents began fighting a lot.

Before deciding how best to address Rachel’s problems and those of her family, Dr. Leon is going to need a lot more information. How can she best understand Rachel? Which of her problems are the most pressing? What diagnosis most accurately describes those problems? Is Rachel genuinely suicidal or perhaps even dangerous to others? What role do her parents play in her current and past difficulties? How can an effective treatment be designed? To answer these questions, Dr. Leon must conduct a clinical assessment (we describe that assessment in Chapter 11).

Clinical assessment is the collection and synthesis of information to reach a clinical judgment about people and their problems. It is a special version of the kind of assessment that most of us engage in almost every day. For example, whether we realize it or not, we are continually collecting, processing, and interpreting information about the background, attitudes, behaviors, and characteristics of the people we meet. We then use this information, along with our experiences and expectations to form impressions that guide our decisions to seek out some people and avoid others. Clinical psychologists collect and process assessment information in ways that are more formal and systematic, but clinicians know that, like the

rest of us, they can make mistakes. Some of their errors are random, as in the case of a clinician who diagnoses bipolar disorder when it is absent, but just as frequently fails to diagnose the disorder when it is present. Other errors are systematic, as in the case of a clinician who tends to see the same disorder in almost all clients. Such systematic errors are known as *biases*.

Clinical assessment
The collection and synthesis of information to reach a clinical judgment about people and their problems.

As we mentioned in Chapter 2, in the decades before psychotherapy became a major role for clinical psychologists, assessment was their most common applied activity. That is no longer the case, but assessment remains a critical part of clinical psychology training and practice. After all, as in the case of Rachel, assessment is required to better understand a client's problems, provide an accurate diagnosis, plan treatments, measure treatment effectiveness and other research variables, and answer a multitude of additional questions (Antony & Barlow, 2010). Without clinical assessment, high-quality research on the causes, correlates, and treatment of mental disorders would be essentially impossible, because clinical scientists cannot fully understand a phenomenon without first being able to measure it. In this chapter, we consider what practitioners and researchers in clinical psychology have learned about the many challenges of clinical assessment and how best

to meet those challenges. Then, in the next two chapters, we'll tell you about the specific types of assessment instruments they employ.

An Outline of the Assessment Process

Section Preview Assessment involves a series of steps, beginning with a problem or referral and ending with the psychologist's communicating the results of the assessment to appropriate parties. In between, the clinician must make a number of decisions, such as which instruments to use and how best to convert clinical assessment data into a clinical judgment. At each step, the clinician must engage in activities to ensure that the most relevant data are gathered and analyzed.

Psychologists have described clinical assessment in various ways (Tallent, 1992), but as in the case of Rachel, all of them portray it as a process of gathering information to answer a question: What is this client's diagnosis? What are her major ongoing problems? Is she at high risk of suicide? Will she benefit from treatment, and if so, what kind of treatment? And so on. In all cases, clinical assessment activities should be organized in a sequence of systematic, logically related steps driven by a goal. Most assessments follow the general sequence outlined in Figure 3.1.

I	II	III	IV	V
Receive and clarify the referral question	Plan data collection procedures	Collect assessment data	Process data and form conclusions	Communicate assessment results

Figure 3.1 A Schematic View of the Clinical Assessment Process

Receiving and Clarifying the Referral Question

Clinicians must answer two related questions before they begin the clinical assessment process (McReynolds, 1975): What do I want to know, and how best can I find out about it? Answers to the first question— what do I want to know?—depend on who requested the assessment and for what purpose. The person or agency requesting the psychological assessment is called the *referral source*, and the question or issue to be addressed is called the **referral question**. (Information that initiates an assessment is sometimes called the *presenting problem*, but we prefer to begin with a referral question because a specific question focuses on the assessment goal, whereas the presenting problem is often a longer description of the client's difficulties.)

Referral question
The trigger that shapes the clinician's choice of assessment instruments and the interpretation and communication of results.

The referral question is very important, because it shapes the clinician's choice of assessment instruments and the interpretation and communication of results. In dealing with Rachel Jackson, Dr. Leon will be conducting an assessment for her own use in deciding how to proceed, but this is not always the case. Clinicians are commonly asked to conduct and report the results of assessments for use by others, and in these cases, it is vital that these clinicians fully understand the context of the referral, including by helping

their referral sources to clarify the purpose of the assessment (Harwood, Beutler, & Groth-Marnat, 2011). In doing so, clinicians may need to educate others about what a psychological assessment can and can't reveal. They may also need to highlight the practical and ethical constraints involved in conducting assessments.

The referral question is the first step in shaping the ultimate goal of assessment. In general, the clearer the goal, the clearer the question. As you can see in Table 3.1, referral questions can be quite varied.

Table 3.1 Examples of Referral Questions from Various Sources

Source	**Referral Questions**
Therapist	Would this person be a good candidate for group psychotherapy? How effective have I been in treating clients with anxiety disorders?
Physician or treatment team	What is the correct psychological diagnosis for this client? What cognitive and emotional limitations does this person have following her accident, and what strengths does she have to draw on during rehabilitation?
Client	What, if anything, can be done to save my marriage? Would I be good at this kind of job? How can I worry less and enjoy my life and my family more?
School	What is an appropriate educational placement

	for this child? How should we intervene to help this student better manage violent tendencies and problems in relationships with peers and teachers?
Parent	Is my child suffering from depression and is she in need of counseling? How can we help my child cope with the loss of his mother? My child becomes very emotional and refuses to go to school: what can I do?
Court	Does this person pose an imminent threat of danger to self or others? Which custody arrangement is in the best interest of this child? Is this client able to understand the criminal charges against him and to assist an attorney in mounting a legal defense? Has this person sustained psychological injuries that would be relevant to litigation?
Employer, government agency, or other third party	Is this person suffering from a mental illness that would qualify for disability payments? What form of treatment would best help this person to resume productive employment, and for which types of employment would the person be best suited? Will the survivors of this natural disaster benefit from rapid intervention, and if so, what kind of intervention?

Planning Data Collection Procedures

Answers to the second question about assessment—how best can I find out what I need to know?—come into play after clarifying the referral question and the clinician's role in the assessment process. With a clear goal now in mind, the clinician can begin planning data collection methods.

There is a vast range of data that might be collected about a client. To illustrate, consider the sheer number of things that Dr. Leon might be asking herself about Rachel. As shown in Table 3.2, her questions can focus on many interrelated levels, from biological functioning to social relationships. The enormous diversity of possible assessment data means that clinicians can never learn all there is to know about their clients, so they typically seek the most detailed information in the areas that are most relevant to the client and the goal of assessment.

Table 3.2 Information Used in a Case Study Guide

This generic case study guide contains some of the topics typically explored in clinical assessment.

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1. Identifying data, including name, sex, occupation, income (of self or family), marital status, address, date and place of birth, religion, education, cultural identity.

2. Reason for appearance or referral, expectations for service.

3. Present and recent situation, including dwelling place, principal settings, daily activities, number and kinds of life changes over several months, impending changes.

4. Family constellation (family of origin), including descriptions of

parents, siblings, other significant family figures, and client's role growing up.

5. Early recollections, descriptions of earliest events and their circumstances.

6. Birth and development, including age of walking and talking, problems compared with other children, view of effects of early experiences.

7. Health and physical condition, including childhood and later diseases and injuries; current prescribed medications; current use of unprescribed drugs, tobacco, or alcohol; comparison of own body with others; habits of eating and exercising.

8. Education and training, including subjects of special interest and achievement, out-of-school learning, areas of difficulty and pride, any cultural problems.

9. Work record, including reasons for changing jobs, attitudes toward work.

10. Recreation, interests, and pleasures, including volunteer work, reading, view of adequacy of self-expression and pleasures.

11. Sexual development, covering first awareness, kinds of sexual activities, and a view of adequacy of current sexual adjustment.

12. Romantic relationships and family data, covering major events and what led to them, and comparison of present family with family of origin, ethnic or cultural factors.

13. Social supports, communication network, and interpersonal interests, including people talked with most frequently, people available for various kinds of help, amount and quality of interactions, sense of contribution to others, and interest in community.

14. Self-description, including strengths, weaknesses, ability to use imagery, creativity, values, and ideas.

15. Choices and turning points in life, a review of the client's most important decisions and changes, including the single most important occurrence.

16. Personal goals and view of the future, including what the client would like to see happen next year and in 5 or 10 years, and what is necessary for these events to happen, realism in time orientation, ability to set priorities.

17. Adequacy of client's functioning in various social roles (e.g., as student, parent, friend).
18. Signs and symptoms of various disorders.
19. History of abuse or other environmental influences (e.g., poverty, experiences of discrimination).
20. Evidence of suicidal or homicidal thinking.
21. Any further material the client may see as omitted from the history.

Source: Items 1–16 adapted from Sundberg (1977). Sundberg, N. D., *Assessment of persons* (1st ed.), © 1997, pp. 97–98, 207. Reprinted and electronically reproduced by permission of Pearson Education, Inc., Upper Saddle River, New Jersey.

The referral question is the most important factor in the selection of assessment instruments, but other factors can also play a role. One of these is the quality of each assessment instrument or procedure. Obviously, clinicians would be better off selecting assessment methods with the best *psychometric properties;* as described later in this chapter, these include reliability, validity, and utility. But the choice may not always rest on psychometrics alone. For example, if Test A has acceptable, though slightly lower,

reliability than Test B, but provides information that is more relevant to the referral question in Rachel’s case, Dr. Leon might justifiably select Test A. In deciding on assessments, clinicians must also consider the client’s characteristics, and select instruments that are most appropriate in terms of reading level, length, and the like. Similarly, clinicians must explain to their clients the procedures and purposes of the whole assessment process, using language that the clients can understand.

In short, clinicians must think broadly when planning assessments, weighing the features of assessment instruments against practical considerations such as time available, the assessment context, and the usefulness of each instrument to clients and referral sources (Hunsley & Mash, 2010). The clinician must also keep in mind that assessment results will eventually have to be combined and integrated in a narrative report that is clear, understandable to others, and meets the original assessment goals.

Collecting Assessment Data

Once the referral question has been clarified, the appropriate assessment methods have been selected, and the client's cooperation and informed consent have been secured, the data collection stage of assessment can begin.

The Value of Multiple Assessment Sources. Clinical psychologists can collect assessment data from four main sources: interviews, observations, tests, and historical records (case history data). However, they seldom rely on a single assessment source to create a working image of a client. Instead, they use multiple assessment channels to cross-validate information about a wide variety of topics. Thus, hospital records may reveal that a patient has been there for 30 days, thereby correcting the client's self-reported estimate of 2 days. Indeed, the whole story of a client's problems is seldom clear until the clinician has accessed multiple assessment sources. For example, people have been observed to be assertive in social situations even though they described themselves in an interview or questionnaire as generally unassertive (Nietzel & Bernstein, 1976).

Another benefit of using multiple assessment sources appears when the clinician evaluates the effects of treatment. Suppose a couple enters therapy because they are considering divorce, and then, 3 months later, they do divorce. If the only outcome assessment employed in this case were "marital happiness," as expressed during interviews, the treatment might be seen as having worsened the couple's marital distress. However, observations, third-person reports, and life records might show that one or both partners find their newly divorced status liberating and that they are cultivating new interests and skills.

Processing Data and Forming Conclusions

After clinicians have collected assessment data, they must determine what those data mean. If the information is to be useful in reaching the original assessment goals, it must be converted from raw form into interpretations and conclusions that address one or more referral questions. This data-processing task is formidable because it requires an inferential leap from known data to what is assumed to be true on the basis of those data. In general, the larger the leap from data to assumption, the more vulnerable to error the clinical inference becomes.

Consider this actual example: A young boy is sitting on a lawn cutting an earthworm in half. It would be easy to infer from these observational data that the child is cruel and aggressive and that he might become violent later in life. These inferences would be off the mark, however, for "what the observer could not see was what the boy, who happened to have few friends, thought as he cut the worm in half: 'There! Now you will have someone to play with'" (Goldfried & Sprafkin, 1974, p. 305). In short, elaborate inference, especially when based on minimal data, can be dangerous.

Processing assessment data is difficult also because we must somehow integrate information from diverse sources. Unfortunately, there are few scientifically based guidelines for how best to combine data from interviews, tests, observations, and other sources to reach conclusions. So in forming their conclusions, clinicians often must rely heavily on clinical judgment, a controversial topic we describe in some detail later in this chapter.

Communicating Assessment Results

The final stage in the assessment process is the creation of an organized presentation of results called an *assessment report*. To be of greatest value, assessment reports must be both clearly written and clearly related to the goals that prompted the assessment in the first place. If one of those goals was to place Rachel Jackson's behavior into a diagnostic category, information relevant to diagnostic classification should be highlighted in the report. If assessment was aimed at determining her likely cooperativeness in and responsiveness to psychotherapy, the report should focus on those topics. These simple, self-evident prescriptions are sometimes ignored in assessment reports, especially when assessment goals were never explicitly stated or when clinicians do not fully understand what their assessment instruments can, and cannot, reveal about clients.

In Review An Outline of the Assessment Process

<table>
<tr><td>Basic questions to be answered before assessment begins</td><td>What do I need to know?
How best can I find out what I need to know?</td></tr>
<tr><td>Basic steps in assessment</td><td>Receive and clarify the referral question.
Plan data collection procedures.
Collect assessment data.
Process data and form conclusions.
Communicate assessment results.</td></tr>
<tr><td>Main sources of assessment data</td><td>Interviews, observations, tests, and historical records.</td></tr>
<tr><td colspan="2">Test Yourself

1. The goals of clinical assessment are determined mainly by the ____________.

2. Decisions about what assessment information to focus on are determined mainly by the __________ and the ____________.

3. Clinicians generally choose assessment instruments that have the best __________.

You can find the answers in the Answer Key at the end of the book.</td></tr>
</table>

The Goals of Clinical Assessment

Section Preview Most referral questions relate to diagnosis, description, treatment planning, or prediction. In this section, we first consider diagnostic classification, the labeling of psychological problems, a process based mainly on criteria in the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association. You will see, though, that a diagnosis alone seldom tells clinicians all they want to know about a client, so they usually also assess clients' strengths, weaknesses, and social connections. Making diagnoses and collecting other information helps clinicians design treatments for each client and measure the effectiveness of those treatments. These assessment goals are increasingly important in this era of accountability and evidence-based practice. You will also see that clinicians sometimes conduct assessments to make prognoses or predictions, and that the accuracy of these difficult judgments can be improved by attending to the lessons provided by years of research on this task.

Classification and Diagnosis

Once clinical psychologists began working with adult clients during and after World War I, their assessment functions began to include determining the nature of their clients' mental disorders. This process is variously called psychodiagnosis, differential diagnosis, or diagnostic labeling. Accurate diagnosis is important for several reasons. First, proper treatment decisions typically depend on knowing what is wrong with a client (Harwood, Beutler, & Groth-Marnat, 2011; Hays, 2013). Second, research on the causes of psychological disorders requires that each of them can be accurately identified and differentiated from other disorders. Third, accurate diagnosis allows clinicians to efficiently communicate with one another about disorders in a professional "shorthand" (Lilienfeld, Smith, & Watts, 2018; Sartorius et al., 1996).

Today, assessment for the purpose of diagnosis remains a significant part of clinical research and practice. For example, Dr. Leon might well describe Rachel Jackson's problems as displaying conduct disorder, or perhaps major depressive disorder. How would she decide? Like other clinicians in North America, she would probably refer to the latest edition of American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, or *DSM-5*. This manual provides an extensive list of mental disorders, classified by type, along with lists of criteria that clinicians can use in deciding which diagnostic category best describes each client.

A Brief History of the DSM. Various methods for classifying mental disorders had been available since the early 1900s, but the process became more formalized in 1952 when the first *Diagnostic and Statistical Manual of*

Mental Disorders was published. Known as *DSM-I*, it remained in use until 1968, when—to make the *DSM* more similar to the World Health Organization's *International Classification of Diseases*—it was replaced by *DSM-II*. *DSM-I* and *DSM-II* provided a uniform terminology for describing and diagnosing abnormal behavior, but they offered no clear rules to guide mental health professionals' diagnostic decisions.

That situation changed in 1980 with the appearance of *DSM-III*, which included a set of (a) explicit diagnostic criteria, and (b) algorithms, or decision rules, for combining these criteria into a diagnosis. The criteria —which referred mainly to the presence of specific symptoms and symptom durations—became more numerous and more specific in subsequent editions, including a revised version of *DSM-III (DSM-III-R*, 1987), *DSM-IV* (1994), and its slightly revised version called *DSM-IV-TR* (2000). So starting with *DSM-III*, clients were diagnosed with a particular disorder only if they met a pre-established number of criteria from the full list of criteria associated with that disorder. This system not only helped to guide clinicians' diagnostic decisions, but greatly facilitated research on psychopathology by ensuring that when a researcher publishes an article about, say, "bipolar disorder," the clients involved were broadly similar to those being studied by other researchers interested in this condition.

DSM-5. Creating a new edition of the *DSM* is always a major enterprise that takes years and requires the coordinated efforts of thousands of scholars who are experts in specific disorders. It also depends on input from numerous work groups, research studies, and field trials of draft versions. Publication of the latest *DSM*, *DSM-5* in May of 2013 was preceded by public comment periods, during which interested people expressed their views on proposed changes (see www.dsm5.org). Like its predecessors, the new edition of the

DSM was designed to be an improvement over previous ones, and to serve as the primary diagnostic classification system for mental health professionals in North America and much of the rest of the world.

Among the most important changes introduced in *DSM-5* was the new organization of its chapters. Some *DSM-IV* categories have changed, as have some of the diagnoses within those categories. For instance, in *DSM-IV*, bipolar disorders and depressive disorders both appeared in the mood disorders chapter. In *DSM-5*, these disorders now appear in separate chapters—one for bipolar and related disorders and one for depressive disorders. Obsessive-compulsive disorder was included in the anxiety disorders chapter of *DSM-IV*, but now headlines its own chapter that also includes body dysmorphic disorder, hoarding disorder, hair-pulling ("trichotillomania") disorder, and skin-picking ("excoriation") disorder (American Psychiatric Association, 2013). The table of contents has also changed (see Table 3.3). The first chapter of *DSM-5* is now focused on neurodevelopmental disorders, many of which are diagnosed in infancy or childhood. These include intellectual disability (formerly called mental retardation), autism spectrum disorders, attention-deficit hyperactivity disorder, specific learning disorders, motor disorders, and various communication disorders. Disorders first identified in childhood are also placed first within each of the other chapters.

Table 3.3 Significant Changes in the Diagnostic and Statistical Manual of Mental Disorders-5 (DSM-5)

Clinicians in many countries outside North America rely on the *International Classification of Diseases*, 11th edition (*ICD-11*; World Health Organization, 2018a) as an alternative to *DSM-5*. In fact, the numerical codes for *DSM-5* diagnoses now correspond to those in *ICD-11*. Although most of the major

diagnoses in the two manuals are similar, there are notable differences for certain categories (First, Reed, Hyman, & Saxena, 2015).

Basic Organization
• Disorders presumed to be more influenced by neurological and neurodevelopmental factors now appear first, a change designed to increase similarity with *ICD-11*.
• Disorders with similar features are listed adjacent to each other.
• The multiaxial disorder categorization system introduced in *DSM-III* is discontinued.
Disorder Categories
• New disorders such as disruptive mood dysregulation disorder and binge eating disorder are now listed.
• Disorders such as Asperger's disorder, childhood disintegrative disorder, and pervasive developmental disorder were dropped as distinct diagnoses; their symptoms are now included in a single diagnosis of autism spectrum disorder.
• Depressive disorders and bipolar disorders are now in separate categories.
• Obsessive–compulsive disorder and posttraumatic stress disorder (PTSD) are now in categories separate from anxiety disorders.
• There is a new category of trauma and stressor-related disorders, which includes diagnoses such as PTSD, adjustment disorders, and reactive attachment disorder.
Diagnostic Criteria

• The diagnosis of major depressive disorder no longer includes an exemption for bereavement.

• Substance abuse and substance dependence categories were merged.

Evaluation of the DSM. Like its predecessors, *DSM-5* has generated intense interest and considerable controversy because not everyone is pleased with the *DSM* system in general or with *DSM-5* in particular. Critics of the *DSM* have long questioned whether the all-or-none categorizations imposed by *DSM* criteria are the best way to understand and measure psychopathology. If individuals meet a certain number of criteria, they are said to "have" a disorder; if not, they are said not to "have" it. In fact, though, most psychological disorders are present in varying degrees. For example, statistical evidence suggests that there is no clear boundary between being clinically depressed and not being clinically depressed. The same holds for most other psychological conditions, with the possible exceptions of schizophrenia, autism spectrum disorder, and substance use disorders (Campbell & Strickland, 2019; Haslam, Holland, & Kuppens, 2012). So many critics argue that most diagnoses should be considered as extremes along one or more underlying dimensions rather than as discrete categories (Widiger & Trull, 2007).

Others have criticized the *DSM*, including *DSM-5*, for not providing enough useful information about disorders. Behaviorally oriented clinicians, for example, have been concerned that *DSM-5* classification ignores the context in which symptoms occur, thus providing no basis for understanding the meaning or function that a pattern of disordered behavior might have for different clients in different social circumstances (Follette, 1996; Wulfert,

Greenway, & Dougher, 1996). These clinicians ask how much a *DSM-5* diagnosis of, say, conduct disorder would tell us about the environmental factors that caused and now sustain Rachel Jackson's problematic behavior. They would also point out that skipping classes might well justify a diagnosis of conduct disorder if she wants to appear "cool" and hang out with her friends, but it might support an anxiety disorder diagnosis if the reason for skipping is that she finds school to be anxiety provoking. Psychodynamically oriented clinicians have criticized the *DSM*'s emphasis on observable symptoms. They worry that once a diagnostic label is applied on the basis of symptoms, we may think we understand that client, even though the label does not necessarily help us to understand the client's subjective experience of having a disorder (Packard, 2007). They point out that Rachel's conduct disorder diagnosis says almost nothing about her emotions and thinking, or about the underlying psychological conflicts that might give rise to her behavioral problems. For their part, biologically oriented clinicians have argued that the *DSM*'s emphasis on observable features of disorder fails to take into account the role of recent discoveries about the brain circuitry associated with specific disorders (Bracha, 2006; Clark et al., 2017).

Critics also have claimed that the *DSM* excludes certain potentially important conditions because every new version has been largely based on, and applied to, the symptoms of disorder seen in North American populations (Hall, 2005). Also missing from the *DSM* are many types of *relational disorders*, such as couples' conflicts, parental discipline problems, child neglect, sibling conflict, domestic abuse, incest, and the like. These conditions, they say, create considerable physical and psychological suffering and may therefore merit inclusion in the *DSM* (Beach & Kaslow, 2006; First, 2006). In the Jackson family, for example, the problems of each family

member appear to be closely intertwined with those of others; at least some of Rachel's conduct problems may in part be reactions to her father's disengagement from the family and from her parents' marital strife.

Critics have questioned, too, the growing number of diagnoses in *DSM*. The first edition, *DSM-I*, contained 106 diagnoses; in *DSM-5*, there are approximately 350 (see Figure 3.2). This roughly 300% increase in diagnostic categories over four decades has led some to wonder if that many new disorders have been discovered, or whether the increase is instead a consequence of the expansion of the mental health field and practitioners' perceived need to identify and treat a wider variety of conditions (Houts, 2004).

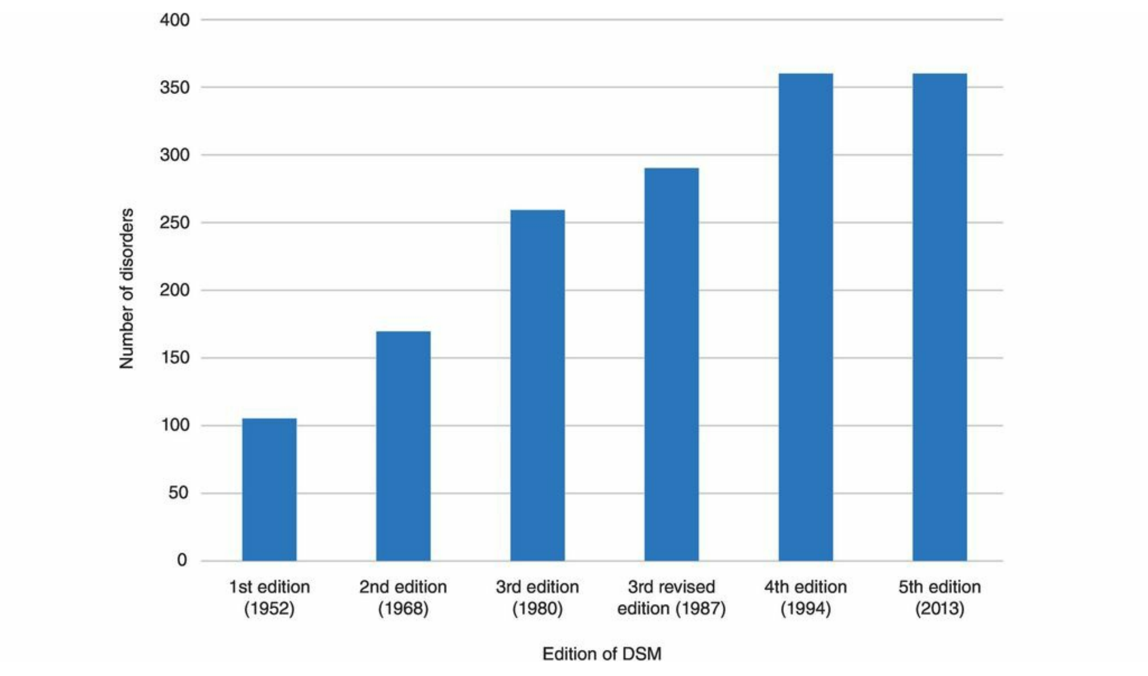

Figure 3.2 Number of Diagnoses in the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* Across Editions
DSM-5 did not substantially change the number of possible diagnoses; rather, it modified the diagnostic criteria for certain disorders and reorganized disorders into 17 broad categories.

Such concerns led members of the Society for Humanistic Psychology (APA Division 32) to send an open letter to the developers of *DSM-5*, complaining about what they perceived as lowered diagnostic standards, the introduction of too many new disorders, and the lack of empirical grounding for some disorders. The result, they contended, is the increased "medicalization" of psychological disorders and a de-emphasis on understanding of the sociocultural factors associated with disorders (Clay, 2012). Others have echoed many of these same concerns, worrying particularly that psychiatrists may be inclined to expand certain diagnostic categories on grounds that may not be entirely evidence-based (Frances & Widiger, 2011; Miller, 2012a). Defenders of *DSM-5* counter that these latter critiques unfairly characterize the activities and motives of honorable professionals who worked hard to create what they see as a more effective diagnostic system (Black, 2013).

Alternative Classification Systems. Clinicians and researchers concerned about the shortcomings of *DSM-5* and *ICD-11* have proposed alternative diagnostic systems. Consistent with criticisms of the *DSM*'s all-or-none, categorical model of diagnosis, numerous scholars have proposed that rather than assigning diagnoses based on whether clients display a specified—and some say largely arbitrary—number of symptoms, clinicians should base diagnoses on measurement of client characteristics on a selected set of dimensions that are relevant for each disorder. These scholars contend that such *dimensional approaches* would avoid the *DSM*'s dichotomies, which may fail to capture potentially useful information about clients. Consider, for example, the diagnosis of borderline personality disorder. *DSM-5* requires that to receive this label, clients must meet at least five of nine diagnostic criteria. This means that a client who meets all nine is placed

in the same diagnostic category as a client who meets only five. How likely is it that these individuals would be similar, let alone the same, on many or most psychological characteristics? The answer is unclear. Arguments for a dimensional approach have been especially persuasive in the diagnosis of personality disorders, where diagnostic reliability has tended to lag behind those of other psychiatric conditions.

To be fair, the *DSM-5* does incorporate a certain amount of dimensional assessment in that it asks diagnosticians to rate the severity of many disorders (American Psychiatric Association, 2013), but some critics contend that the dimensional approach has not been applied broadly enough. Others (e.g., Westen, 2012) suggest that clinicians should diagnose on the basis of the degree to which a given client's characteristics resemble prototypical examples of particular disorders. So rather than noting the presence or absence of symptoms from a disorder checklist, clinicians could rate, on a one-to-five scale, the degree to which a client's behavior matched a prototypical description of each disorder. This approach assumes, however, that every disorder can be described in terms of a single number rather than a set of different dimensions, an assumption that may not hold for many conditions.

Another dimensional alternative that we mentioned in Chapter 2, comes from an international consortium of psychologists and psychiatrists whose members have proposed a Hierarchical Taxonomy of Psychopathology, or HiTOP (Conway et al., 2019; Kotov et al., 2017). The goal of HiTOP is to describe most or all mental disorders in terms of extremes of one or more broad personality dimensions, thereby merging the traditionally disconnected fields of personality and psychopathology (Hopwood et al., 2019). These dimensions including *internalizing*, which includes distress and fear;

externalizing, which includes impulsivity, antisocial behavior, and substance use disorder; and *thought disorder*. So if Dr. Leon were to diagnose Rachel Jackson using the HiTOP perspective, she might describe her as having extremely high levels of externalizing and perhaps high levels of certain facets of internalizing, rather than as having conduct disorder.

Still other diagnostic proposals call for describing psychopathology in terms of specific theories or contextual principles. For instance, Robert Bornstein (2006) argued that psychodynamic concepts such as ego strength, defense style, and mental representation of the self and others have considerable diagnostic utility. This kind of thinking prompted creation of an alternative diagnostic system called the *Psychodynamic Diagnostic Manual* (*PDM*), published in 2006 and revised in 2017 (Lingiardi & Williams, 2017). This manual was developed by a task force whose members represented five major psychoanalytic groups. Advocates of this alternative system argue that it promotes more in-depth assessment. They claim that it also encourages clinicians to look beyond overt disorder features during the diagnostic process and generate more complete pictures of clients, which in turn allows for more sophisticated case formulation and better treatment planning (Brabender & Whitehead, 2011; Huprich & Meyer, 2011). Despite its ambitious goals, the *PDM* appears so far to have had relatively little impact on clinical practice or research.

The field of positive psychology has provided yet another alternative diagnostic approach. Its advocates agree with some other critics that diagnoses based on problematic symptoms alone is insufficient. What is missing, they say, is the systematic assessment of clients' strengths (Ehde, 2010; Joseph & Wood, 2010). In fact, they argue that the "real" psychopathologies, the ones that "carve nature at its joints," might be better

understood as the absence of character strengths, not as the presence of symptoms described by *DSM* (Duckworth, Steen, & Seligman, 2005). One result of this approach is *The Handbook of Positive Psychology Assessment* (Lopez & Snyder, 2003), which describes approaches to assessment based on positive psychology. Another is Peterson's (2006) "Values in Action (VIA) Classification of Strengths: The un-DSM and the Real DSM."

A final, intriguing diagnostic alternative has come from the Research Domain Criteria (RDoC), an initiative recently launched by the National Institute of Mental Health that reflects the increasing movement of clinical psychology and allied fields toward neuroscience. As we mentioned in Chapter 2, from the perspective of the RDoC, mental disorders are best conceptualized as disorders of brain circuitry (Insel, 2014). RDoC advocates argue that the domain of psychopathology can be understood as involving dysfunctions in various psychobiological systems, such as the brain circuits associated with reward processing, threat sensitivity, and social attachment. They suggest that certain anxiety disorders, such as specific phobias, may stem from overactivity in brain systems involved in detecting and reacting to threat, and that clinical depression may stem from underactivity in brain systems involved in reward processing. At the moment, however, RDoC is more of a blueprint for future research than a formal classification system, so it is too early to tell whether it will eventually supplement or even replace the *DSM* or the *ICD* (Clark et al., 2017; Lilienfeld & Treadway, 2016). One of its strengths, though, is that it emphasizes continuous transdiagnostic vulnerability markers that can appear at many different levels of analysis (e.g., genetic, cellular, behavioral), rather than focusing on separate diagnostic categories that do not effectively capture the frequent co-

occurrence, or comorbidity, of disorders (e.g., Janiri et al., 2020; McTeague et al., 2020).

It is no wonder that the diagnostic classification enterprise continues to be a hotbed of controversy. After all, it attempts to differentiate among a wide variety of enormously complex disorders that are caused by multiple, typically poorly understood, factors and that are in part socio-cultural defined. Further, it strives to do so using a relatively small set of shorthand labels organized in a way that is supposed to help clinicians make optimal decisions about their clients. No diagnostic system is likely to ever accomplish all these goals. So although various diagnostic approaches may each have their advantages, it is unlikely that any of them will replace the current categorical classification system in the foreseeable future. For one thing, that system is consistent with the model of discrete diseases that dominates the health-care industry. It also offers an efficient and generally useful shorthand through which clinicians can communicate with each other. The challenge for competing diagnostic schemes, and for the newest version of the *DSM*, is to improve upon diagnostic reliability, validity, and utility while still maintaining a system that is efficient.

Description

Even a classification system that is reliable and valid and serves as an efficient shorthand for communication among mental health professionals and researchers would not be ideal for many clinicians because to them, diagnoses aren't enough. They want to know more, and consequently, some of the proposed alternative diagnostic proposals shade over into *descriptive assessment*, which these clinicians see as equally important, or even more important, than diagnostic classification.

In Rachel Jackson's case, descriptive assessment by a cognitive behavioral therapist would focus on identifying factors such as antecedent conditions, environmental incentives and disincentives in her life, on alternative sources of reward, and on her thinking style, such as the types of attributions she makes for situations and whether she shows a bias toward certain kinds of judgments (e.g., being highly self-critical). A psychodynamic therapist would focus descriptive assessment on her ego strengths and weaknesses, her cognitive functioning and defense mechanisms, the quality of her early parental relationships and current relationships with family and friends, and the characteristics of her sense of self (Gabbard, Litowitz, & Williams, 2012). Still, diagnostic classification and descriptive assessment can go hand in hand. Aksel Bertelsen (1999), for instance, suggested that clinical assessment should work at two levels, one that aims at deciding on a diagnostic classification, and another that seeks to evaluate multiple factors that might influence the course of treatment.

Description-oriented assessment makes it easier for clinicians to attend to clients' assets and adaptive functions, not just to their weaknesses and

problems. Accordingly, descriptive assessment data are used to provide pretreatment measures of clients' behavior, guide treatment planning, and evaluate changes in behavior after treatment. Descriptive assessment can also improve measurement in clinical research. For example, in an investigation of the relative value of two treatments for depression, assessments that describe the details of clients' posttreatment behaviors (e.g., absenteeism, self-reported sadness, and depression test scores) may be of greater value than knowing whether or not they still satisfy the criteria for a diagnosis of depression.

Nevertheless, broader description of clients is unlikely ever to dominate clinical assessment, especially in residential psychiatric settings and other managed-care facilities. The major reason is time. As skyrocketing health-care costs have increased economic pressures to limit hospital stays and to concentrate on focused assessments and short-term treatments, time-consuming and comprehensive patient evaluations are just too expensive. So the degree to which descriptive approaches to assessment gain widespread usage will ultimately depend on their empirically demonstrated usefulness—the degree to which clinicians can perform assessments efficiently and use them to design better research and treatments.

Planning and Evaluating Treatment

Diagnostic and descriptive assessment can be used to plan treatments. In the simplest model, arriving at a diagnosis, such as major depression, leads to a preferred treatment, such as cognitive behavioral psychotherapy, much as a diagnosis of strep throat leads to the choice of treatment with antibiotics. As we mention in Chapters 1 and 7, identifying ideal connections between diagnoses and psychotherapy methods has been a main goal of the empirically supported treatments movement.

Efforts to match specific treatments with specific diagnoses have certainly improved the empirical base of psychotherapy, but the enterprise has not worked out as cleanly in practice as many had hoped. Diagnostic classification remains somewhat unreliable, so it is challenging to argue that specific treatments work for specific diagnoses when the diagnoses themselves are not always precise. The fact that many of them change from one *DSM* edition to the next doesn't help either. Further, as described in Chapter 7, extensive research on the effectiveness of psychotherapy shows that treatments often have general and overlapping effects, some of which have more to do with characteristics of therapists and clients than with the disorders to which they are applied (Beutler & Malik, 2002; Norcross & Lambert, 2011; Singer, 2013; Wampold & Imel, 2015). Because of these problems, clinicians have sought to incorporate other factors into treatment-related assessment. The key is to identify which factors, apart from the diagnosis and the "brand" of psychotherapy, predict how well an intervention will work.

In short, assessment for the purpose of treatment planning goes beyond the basic question that is common in medicine: *Which treatments work best for which disorders?* Instead, it addresses the more detailed question, famously posed by Gordon Paul (1967, p. 44): “*What* treatment, *by whom*, is most effective for *this* individual with *that* specific problem, and under *which* set of circumstances?” In Chapters 6 and 7 we present much more detailed information about assessment for treatment planning and some potential answers to Paul’s “ultimate question.”

Clinical assessment can also address the question of how well treatment has worked. Indeed, clinicians working in today’s accountability-driven climate are increasingly asked to provide evidence of their effectiveness (e.g., Rousmaniere et al., 2019). Generating that evidence requires assessment. There are many ways to assess the results of treatment, including questionnaires, client self-reports, psychological tests, reports by relatives and friends, and the like. For most clinicians, the goal is to record outcomes efficiently and accurately, and to periodically review the data to evaluate how and where a treatment is helping and how and where it might not be helping. Having these outcome data is essential even without the pressure applied by third-party payers because conscientious assessment of one’s treatment effects is part of the professionalism normally expected of clinical psychologists, and indeed of all health-care providers. Moreover, monitoring outcomes throughout the course of treatment allows clinicians to revise their approach as they go if the client is not making the expected progress (Hong et al., 2019; Muir et al., 2019).

As an example of this kind of ongoing outcome assessment, consider a case described by Alan Kazdin (2006):

Gloria, age 39, was self-referred for depression. An initial assessment was conducted, and a treatment plan involving combined cognitive behavioral and interpersonal therapy, administered on weekly visits, was devised. The therapist also had Gloria come about 20 minutes early each week and complete brief measures designed to track her progress. One measure was a rating on a series of statements developed collaboratively between Gloria and the therapist, which they called the G-Scale. Another was an abbreviated version of the Beck Depression Inventory (BDI; Beck, Steer, & Garbin, 1988), and the last was an abbreviated version of the Quality of Life Inventory (QOLI; Frish, 1998). Figure 3.3 presents the session-by-session changes in Gloria's test scores over several weeks of treatment.

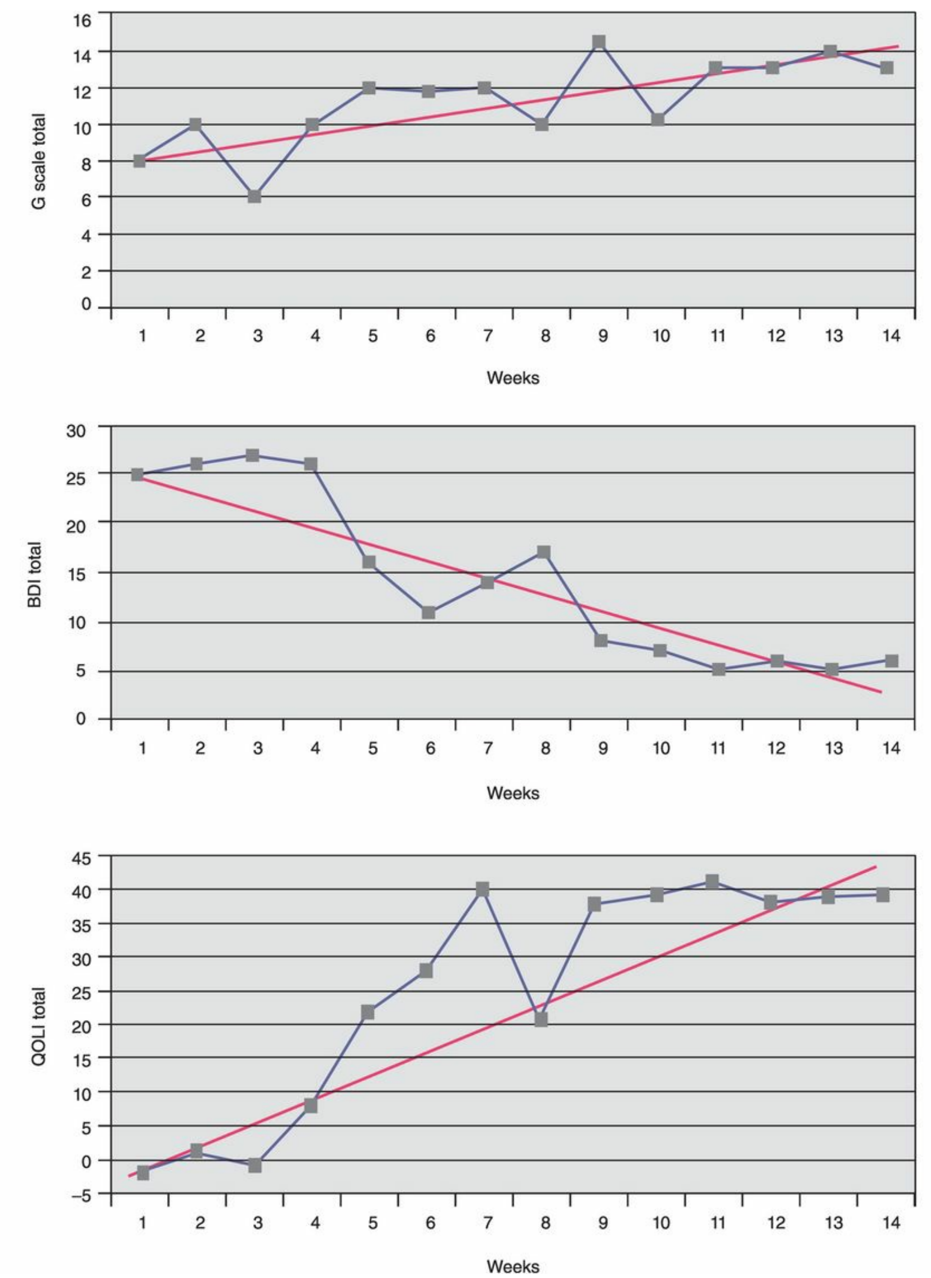

Figure 3.3 Assessment of Gloria's Psychotherapy Progress on Three Measures

The first two weeks can be considered baseline measures. A linear regression line (in red) has been fitted to the data points on each graph.

(Source: Kazdin, A. E., *Research design in clinical psychology* (4th ed.), © 2003, p. 322. Reprinted and electronically reproduced by permission of Pearson Education, Inc., Upper Saddle River, NJ 07458.)

Assessments can also be used as an explicit component of treatment. There is promising evidence, for example, that discussing clients' treatment results with them can have therapeutic value (Finn & Hale, 2013; Poston & Hanson, 2010; Reynolds, 2016). Imagine Gloria and her therapist discussing the assessment results shown in Figure 3.3. Being involved in that discussion might well encourage her to be more objective and accurate in tracking her own behaviors over time, a process known as self-monitoring. It might also increase her trust in the therapist and in the treatment, provide an additional avenue of therapeutic interaction, and perhaps most important, give her greater insight into her strengths and weaknesses. Assessment expertise is a traditional strength of clinical psychologists, so it makes sense to harness that strength in the service of improving therapy results (Hunsley, Smith, & Haynes, 2018; Youngstrom, 2013).

Prediction

A final goal of clinical assessment is to make predictions about human behavior. Those predictions might include forecasts about how the symptoms of a client's disorder might change with or without treatment (that is, a prognosis), about future performance (descriptions of how someone will perform in a given job or situation), or about dangerousness (the likelihood that people will behave violently toward themselves or others). In making any of these predictions, clinicians must obtain valid information about how the characteristics revealed by assessment relate to the behavior being predicted. Without that link, prediction would be little more than guesswork.

Prognosis. Most often, prognosis refers to a prediction about the outcome of treatment, but it can also refer more generally to predictions about changes in symptoms without treatment or under certain circumstances. For example, a head injury might change the prognosis for treatment of an anxiety disorder because the injury might make a client less likely to follow-through on agreed-upon "homework" assignments between sessions.

Many *DSM* diagnoses contain considerable information that is relevant to prognosis, including results of long-term studies of the course of a disorder as well as other data related to the time of its typical onset, chronicity, people who are most at risk, and the like. And although the *DSM* provides few specific prognostic statements, it is not difficult for clinicians to recognize that some disorders tend to be more disabling than others, more chronic or prone to relapses, or more responsive to treatment or to certain positive or negative life circumstances. Clinicians can build on information in the *DSM* to increase the accuracy of their prognoses. For example, assessing a client's

level of social support and subjective distress can alter a prognosis in one direction or another. The *DSM* might suggest that clients with relatively high levels of social support and moderate, but not overwhelming, distress tend to have better prognoses than clients with relatively low levels of support and intense distress.

A prognosis can also be influenced by assessment of such client factors as impulsivity and coping style, and repeated resistance to therapist suggestions. The degree to which a prognosis should be adjusted by other factors should be guided by research evidence about the degree to which each factor has been shown to influence treatment outcomes in similar cases. The other factors include the treatment setting (e.g., inpatient versus outpatient), the “fit” between client and therapist (e.g., shared values or cultural backgrounds), and the client’s beliefs about treatment (Hall et al., 2016; Hundt et al., 2013).

Predicting Performance. Clinicians are sometimes asked by businesses, government agencies, police and fire departments, and the military to help them select people who are most likely to perform well in certain jobs. In such cases, the clinician must first collect and/or examine descriptive assessment results to provide data on which to base predictions and selections. This crucial step is often underappreciated by those who believe clinicians should be able to make predictions in any domain simply on the basis of their general psychological training. To know how someone will perform in a given job or situation, one must have research evidence about which characteristics accurately predict which outcomes. This means that for each job or domain, clinicians must do their homework; they cannot rely exclusively on their assumptions or their clinical judgment.

Examples of clinical assessment programs aimed at predicting

performance appeared during World War II, when psychiatrist Henry Murray used specialized tests, interviews, and observations to select soldiers who would be the most successful spies, saboteurs, and other behind-enemy-lines operatives (Office of Strategic Services, 1948). After the war came large-scale screening programs designed to select civilian and military employees (Institute of Personality Assessment and Research, 1970), graduate students in clinical psychology and psychiatry (Holt & Luborsky, 1958; Kelly & Fiske, 1951), and Peace Corps volunteers (Colmen, Kaplan, & Boulger, 1964). Because such assessment programs inform decisions that affect large numbers of people, they must be evaluated not only for their predictive accuracy, but also for their impact on the people being assessed and on the organizations that use them.

Thinking Scientifically How Good Are Clinicians at Predicting Dangerousness?

Predictions of dangerousness, long a part of clinical practice and research, are usually called *forensic evaluations* (see Chapter 14 for information about other forensic activities). A clinician might be asked, for example, to predict whether an eighth grader who brought a handgun to school poses a homicide risk and should be placed in a secure facility instead of in a regular school (Vincent, 2006) or to estimate the likelihood that an adult sex offender will commit a similar crime if released (Langton et al., 2007). Dr. Leon is faced with the task of predicting Rachel Jackson's risk of attempting suicide. Such predictions are obviously harrowing because they involve life-

or-death situations, either for clients and their loved ones, or those whom the client might harm.

What am I being asked to believe?

Clinicians are asked to do forensic evaluations because referral sources and the general public have developed confidence in their ability to make predictions about dangerousness that are more accurate than what can be expected from nonexperts. These impressions are reflected not only in continued referrals to clinicians, but in media portrayals of forensic psychologists who are capable of uncannily accurate predictions.

What kind of evidence is available to support the claim?

In fact, though, most of the evidence for clinicians' supposed expertise at predicting dangerousness is anecdotal. Some clinical researchers have developed instruments designed to guide and improve their predictions, but there is little scientific evidence to support their value; clinical psychologists and psychiatrists often find it difficult to predict dangerousness accurately (Coid et al., 2011; Fazel et al., 2012; Hilton, Harris, & Rice, 2006).

Are there alternative ways to interpret the evidence, including those that my biases and preconceptions might have kept me from seeing?

It might be tempting to conclude from their predictive failures that forensic clinicians are incompetent, but it is important to first understand the nature of the situation they are facing. One of their biggest problems is that the *base rate*, or frequency with which

dangerous acts are committed in any group of people, is usually very low. The following example shows why the consideration of base rates is crucial. Assume that forensic clinician Dr. Michael Trout is 80% accurate in predicting homicidal behavior. That sounds quite impressive until you take into account that the base rate of homicide in the population with which he works is about one-tenth of 1%, meaning that only 10 people out of 10,000 will ever commit a murder. So if Dr. Trout were to assess 10,000 people, he would correctly predict their dangerousness 80% of the time, and he will be correct in two different ways. First, he will correctly identify 8 (80%) of the 10 truly dangerous people. Second, he will correctly identify as not dangerous 7992 (80%), of the other 9990 people in the population. But although being accurate 80% of the time means that he will be wrong 20% of the time and, again, he will be wrong in two ways. First, he will fail to identify 2 (20%) of the 10 truly dangerous people. Second, he will incorrectly identify as dangerous 1,998 (20%) of the other 9990 people in the population (see Table 3.4). So Dr. Trout's ability to correctly identify 8 out of 10 truly dangerous people must be viewed in light of his labeling of 1,998 people as dangerous when they are not.

Table 3.4 Measuring the Accuracy of Clinical Predictions of Dangerousness

The accuracy of predictions can be evaluated in terms of four possible outcomes. *True positive* outcomes occur when a clinician correctly labels someone as dangerous. *True negatives* occur when a clinician correctly labels someone as not dangerous. *False negatives* occur

when a clinician labels someone as not dangerous when that person actually is dangerous. *False positives* occur when a clinician labels someone as dangerous when that person is not actually dangerous.

	Ultimate Outcome	
Clinician's Prediction	**Actually Dangerous**	**Not Actually Dangerous**
Dangerous	8 (true positives)	1998 (false positives)
Not dangerous	2 (false negatives)	7992 (true negatives)

In other words, correctly predicting low base-rate events such as dangerousness is extremely difficult (Hart & Cooke, 2013). In the example described in Table 3.4, Dr. Trout's *positive predictive power* to identify dangerous people would be woefully low (less than 1% of his predicted murderers will actually kill), while his accuracy in predicting nondangerousness, called *negative predictive power*, would be greater than 99.9%. Dr. Trout could play it safe by saying that no one will commit a murder; after all, he would be correct 99.9% of the time. However, all of his errors would then be false negatives (labeling dangerous people as safe), and society sees such mistakes as more serious than false positives (labeling safe people as dangerous). So, we should be skeptical when a politician or media personality proclaims "we should have been able to foresee this horrible school shooting given what we know now." In fact,

forecasting such rare events is far more difficult than most people realize.

What additional evidence would help to evaluate the alternatives? Researchers who seek to improve the prediction of dangerousness are now focusing on combining assessment evidence from four domains: (a) personality traits, such as anger or impulsiveness; (b) clinical factors, such as evidence of mental or personality disorders; (c) historical factors, especially a record of violence; and (d) contextual factors, such as the strength of social support from family and friends (Buchanan et al., 2019; Cassel & Bernstein, 2007). So in working with Rachel Jackson, Dr. Leon will explore all four domains, and will no doubt ask Rachel about her suicidal thoughts, her desire to die (Baca-Garcia et al., 2011), whether she has made attempts at suicide, and if so, what kind and how many, and when (Ougrin, et al., 2012). She may also ask Rachel to give her own estimate of her potential for suicide (Peterson, Skeem, & Manchak, 2011), and about her reasons for living (e.g., to care for a family pet and not upset her twin siblings). Suicide risk assessment also involves asking Rachel about her access to lethal means (e.g., a large number of pills or a gun), her willingness to remove that access, and other ways to lower risk (e.g., agreeing not to drink heavily if alcohol makes her more impulsive). Dr. Leon will use assessment information from all available sources to adjust upward or downward the estimated risk of suicide, as derived from a validated suicide risk assessment approach (e.g., Belsher et al., 2019; Melhem et al., 2019; Pisani, Murrie, & Silverman, 2015; Ribeiro et al., 2019; Rudd, 2014). In addition, she

will consult published literature on evidence-based risk assessment and prevention in an effort to improve the accuracy of her prediction about Rachel’s own risk (Pompili & Tatarelli, 2011; Tello et al., 2020).

What conclusions are most reasonable given the kind of evidence available?

The American Psychiatric Association (1983) has stated that psychiatrists have no special knowledge or ability that allows them to accurately predict dangerous behavior, and the same is no doubt true for clinical psychologists. As a result, most clinicians choose to err on the side of caution by overpredicting dangerousness. So when trying to identify the tiny minority of students who are likely to engage in violence at school, clinicians know that—because of the extremely low base rate of violence—many of their predictions will be false positives. For every correctly identified school shooter, dozens or hundreds of other students may suffer the consequences of being falsely identified as potential killers (Cunningham, Sorensen, & Reidy, 2009; Mulvey & Cauffman, 2001).

Are these false positives the price we have to pay to try to eliminate false negatives? It would appear so, but those who attempt to predict dangerousness do try to minimize errors by following certain guidelines. First, clinicians usually prefer to make predictions about the probability of danger or the level of risk (e.g., high, moderate, low) rather than about whether a particular individual will or won’t commit a particular act. Second, they try whenever possible to base their predictions on one of several assessment instruments that

are designed to predict dangerousness. Although none of these instruments has shown better than modest predictive accuracy (Yang, Wong, & Coid, 2010), they are still better predictive guides than are guesses based on clinical judgment and intuition.

In Review The Goals of Clinical Assessment

Main goals of assessment	Classification and diagnosis, description, planning and evaluating treatment, and prediction.
Approaches to diagnosis	Standard classification systems and criteria (e.g., *DSM-5* or *ICD-11*). Alternative systems such as the Hierarchical Taxonomy of Psychopathology (HiTOP), the Psychodynamic Diagnostic Manual (PDM), the Handbook of Positive Psychology Assessment, and the Research Domain Criteria (RDoC). Descriptive systems that provide information that goes beyond diagnostic labels.
Combining assessment information	Diagnoses and broader descriptions of clients can guide treatment planning, help evaluate treatment, and even become part of treatment.
Assessment for prediction	Clinicians may be asked to give prognoses about the course of a client's disorder, to predict future performance in educational or occupational settings, and to identify clients who are likely to be a danger to themselves or others.

Test Yourself

1. The most important goals of diagnostic classification are to _________, _________, and ___________.

2. Many of the most influential alternatives to clinical diagnosis are called ________ approaches.

3. The biggest problem for clinicians attempting to identify murderers and other dangerous people is the fact that violent acts are __________.

You can find the answers in the Answer Key at the end of the book.

Factors Influencing the Choice of Assessment Instruments

Section Preview The goals of assessment are the most important factors in determining a clinician's choice of assessment tools for clinical or research purposes, but in this section you will see that a number of other factors also play a role. Among the most influential of these are the psychometric properties that serve as the "credentials" of assessment instruments, including reliability, validity, standardization, and utility, the clinician's level of experience and theoretical orientation, the situation in which assessment occurs, and a variety of cultural factors.

Sound clinical judgments depend on the soundness of the tests and other assessment instruments clinicians use to help make those judgments (Ayearst & Bagby, 2010). Let's now briefly consider the key dimensions that determine the psychometric quality of all assessment instruments, especially their reliability and validity. In the next two chapters, we will provide more detail about how some of the most widely used tests, interview protocols, and observational systems fare along these dimensions.

Reliability

The **reliability** of an assessment instrument refers to the consistency with which it measures some target variable, such as depression or intelligence. There are several ways to evaluate reliability, and they do not always yield the same results. One way is to use repeated measurements. If the results of the same test with the same clients are very similar, that test would be said to have high *test–retest* reliability, much as a bathroom scale would if it shows the same weight reading when someone steps off it and then steps back on. Reliability can also be measured in terms of *internal consistency*. This can be done by comparing results from two parts of a test, such as all the odd-numbered items versus all the even-numbered items. If the results of the two sets of items are strongly correlated, the test is said to be internally consistent (the internal consistency in this particular example is known as *split-half reliability*). Finally, we can evaluate an assessment instrument in terms of *interrater reliability,* which is measured by comparing the conclusions drawn by different clinicians using the same assessment system to diagnose, rate, or observe the same clients. When clinicians judging the same set of assessment results arrive at significantly differing conclusions, interrater reliability is low. The more they agree, the higher is the interrater reliability.

Reliability

In clinical assessment, the consistency with which an instrument measures some target.

Interrater reliability tends to be higher when clinicians base their judgments on the same set of relatively clear criteria (such as the ones the *DSM-5* provides for diagnosing panic disorder), or the same set of interpretive rules. Interrater reliability tends to be lower when clinicians base their judgments on more subjective criteria (such as the ones *DSM-5* provides for diagnosing borderline personality disorder). Differences in the clarity of diagnostic criteria help explain why, as with previous *DSM*s, interrater reliability is high for many or most disorders (e.g., posttraumatic stress disorder) and unacceptably low for others (e.g., generalized anxiety disorder; Freedman et al., 2013). Interrater reliability also tends to be low in the case of unstructured interviews and projective techniques. These latter instruments often yield results that are ambiguous enough to be open to widely different subjective interpretations.

To achieve the best assessment results, clinical scientists must pay close attention to published research on the reliability of the methods or instruments they are considering for use with a given client or in a particular clinical research project.

Validity

The **validity** of an assessment method reflects the degree to which it measures what it is supposed to measure. Like reliability, validity can be evaluated in several ways. Psychologists who study measurement (psychometricians) describe all major forms of validity in terms of one overarching concept, namely, *construct validity* (pronounced “CON-struct”; Clark & Watson, 1995; Cronbach & Meehl, 1955; Loevinger, 1957. Messick, 1995). To oversimplify matters somewhat, an assessment instrument is said to possess good construct validity when its results are systematically related to the construct or attribute that it is supposed to be measuring. Examples of psychological constructs include intelligence, schizophrenia, and extraversion. These phenomena are not directly observable, but they are hypothesized to exist in varying degrees across people.

Validity

In clinical assessment, the degree to which an instrument measures what it is supposed to measure.

To evaluate construct validity, psychologists ask whether a test or other assessment method yields results that make sense in light of some theory about human behavior and mental processes. For example, scores on a new test of anxiety should be higher among people in circumstances—such as facing major surgery—that are assumed to increase anxiety. If those people’s

test scores are no higher than, say, healthy people listening to calming music, the construct validity of that anxiety test would be suspect. A full evaluation of construct validity does not result from just one set of comparisons, though. It requires the gradual accumulation of results from diverse studies and an elaborate set of statistical analyses (Campbell & Fiske, 1959; Westen & Rosenthal, 2003).

There are several subtypes of construct validity. The *content validity* of an assessment method is determined by how well it captures all the relevant dimensions of its target construct. An interview-based assessment of depression that includes questions about sad feelings, but asks nothing about other key features of depression, such as lack of concentration, feelings of guilt, worthlessness, or fatigue, would have low content validity. *Criterion validity* reflects how strongly the results of an assessment method correlate with some important outcome, or criterion. One form of criterion validity is called *predictive validity* because it is measured by evaluating how well the results of an assessment method forecast events such as violent behavior or suicide attempts. A second form of criterion validity, called *concurrent validity,* reflects the degree to which the results of an assessment method are similar to those of other methods that are designed to measure the same construct. So if people's scores on that new anxiety test are about the same as the scores they earned on other anxiety tests, the new test's concurrent validity would be high. At the same time, if a test really is mainly measuring anxiety, its scores should correlate more highly with existing measures of anxiety than with measures of different conditions, such as schizophrenia. If that is the case, the anxiety test can also be said to possess *discriminant validity*, the extent to which results coming from measures of one construct

are largely unrelated to theoretically irrelevant constructs (Campbell & Fiske, 1959; Shaffer, DeGeest & Li, 2016).

Validity is related to reliability because an assessment device cannot be valid without first being reliable. Still, the validity of an instrument is not guaranteed just because it is reliable. To illustrate, imagine that a researcher notices that very anxious people tend to pull their hair more than less anxious people do, and claims that people's typical level of anxiety can be measured by counting the amount of hairs on their heads. Assuming an accurate method is available for identifying the percentage of the skull covered by hair, that percentage would be a *reliable* measure of anxiety; it would remain fairly stable over short periods of time, and different observers using the same measurement tool would presumably agree on the results. But this highly reliable measurement of hairiness would be a highly *invalid* measure of trait anxiety. That's because the amount of hair on people's heads can be due to their age, gender, health habits, genetic proneness to baldness, and a host of factors entirely unrelated to anxiety.

Reliability and validity are matters of degree, not all-or-none characteristics. The question clinicians must ask is how much imprecision is tolerable in an assessment instrument. If your bathroom scale varied by only a few ounces in an assessment of its test–retest reliability, you would probably still consider it reliable enough for weighing yourself, but if a postal scale varied by that much, you would probably consider it unacceptably unreliable because you would attach too little postage or too much. The amount of error clinicians can tolerate in their assessment instruments depends on the goals and potential uses of the assessment enterprise, on the availability of alternative measurement instruments, and on practical constraints, such as time and resources. Remember, too, that the validity of

an assessment instrument must always be viewed in relation to the purposes for which it is used. For example, a test might be a valid measure of typing skill but an invalid measure of aggressiveness, and the ability to solve a large number of arithmetic problems in 60 seconds might be a valid measure of information processing but an invalid measure of rational thinking. Test validity can reasonably be assessed only when tests are used for the purposes for which they were intended.

In the final analysis, clinicians’ choice of assessment instruments should be based on which of several instruments designed for the same purpose have the best reliability and validity, all other considerations being equal.

Standardization

Most of the tests of intelligence, personality, and psychopathology that you will read about in Chapter 5 are *standardized*, which means that their developers have given the tests to a large, representative sample of people and analyzed the scores. This **standardization** process gives the developers information about the average score that can be expected in a population—the average mathematics score for 7-year-old children, for instance. It also gives information about the typical variability of scores on individual items or subtests. Without such information, clinicians would have no way to determine whether a given client's score on a test was average, below average, or above average.

Standardization
The process of administering a test or other assessment method to samples of people that are large enough and representative enough to establish clinically useful norms for interpreting a client's score on those assessments.

Still, in evaluating tests and other assessment instruments, clinical scientists must pay close attention to the question of whether the standardization sample was sufficiently large and representative. To the extent that it was not, confidence in the value of the instrument is limited, especially if the standardization sample did not include clients like the ones a

clinician typically encounters. Suppose, for example, that a clinician suspects that a recent immigrant from China might have a somatoform disorder and wants to use the standardized set of questions from a well-researched structured interview to help guide the diagnosis. If that structured interview has not been validated on Chinese populations, the client's responses might not be interpretable on the basis of the test's standardization procedures.

Bandwidth Versus Fidelity: A Complex Tradeoff

Clinicians' assessment choices are further guided by their attempts to resolve the **bandwidth–fidelity** (or the breadth–depth) **dilemma** (Hogan & Roberts, 1996; Shannon & Weaver, 1949). Just as greater bandwidth is associated with lower fidelity (a clearer signal) in broadcasting, clinicians have found that, given limited time and resources, the more extensively they explore a client's behavior, the less intensive each aspect of that exploration tends to become (and vice versa). The breadth of an assessment method is thus referred to as its *bandwidth* and the depth or detail of the information it yields is called its *fidelity* (Cronbach & Glesser, 1964). If, during a 2-hour interview, a clinician asks a long list of questions, the result would be relatively superficial information about a wide range of topics (broad bandwidth, low fidelity). If the same amount of time is spent exploring the client's early childhood memories, the result would be a lot of detailed information about only one aspect of the client's life (narrow bandwidth, high fidelity).

Bandwidth–fidelity dilemma
The fact that in clinical assessment, the more detailed one's exploration is, the fewer topics can be addressed, and the more topics are explored, the less detailed the exploration can be.

With this dilemma in mind, clinicians seek assessment strategies and measurement tools that yield an optimum balance of bandwidth and fidelity

for the assessment tasks at hand. The questions, levels of inquiry, and assessment techniques that will be useful in identifying stress-resistant executives differ substantially from those that will help detect brain damage in a 4-year-old child.

Other Factors Affecting Assessment Choices

Psychometric quality and bandwidth–fidelity questions are important factors in determining which assessment methods clinical practitioners and researchers choose, but they are not the only ones. Their choices are also influenced by their theoretical orientation, their experience with various methods, the context in which they will conduct the assessment, and the cultural background of their clients or research participants.

Clinicians' Experience and Theoretical Orientation. Clinical psychologists may use or avoid specific assessment methods because those methods were either emphasized or criticized by faculty in their graduate training programs. Similarly, those who find certain measurement tactics tedious or unrewarding tend to seek answers to assessment questions through other procedures with which they feel more comfortable. A clinician's comfort level with an instrument should not be a major criterion for selecting it because sometimes clinicians become so comfortable with certain assessment methods that they use them even when they are not optimal for the task at hand. These clinician-specific factors help explain why some assessment methods continue to be used by some practitioners even when research evidence fails to support their reliability, validity, or both.

Clinicians' differing theoretical orientations can also lead them to pursue certain questions and concerns and pay little or no attention to others; in effect, their orientation provides an outline for assessment. So psychodynamically oriented case descriptions tend to include material about unconscious motives and fantasies, ego functions, early developmental periods, object relations, and character structure (e.g., Gabbard, 2010).

Cognitive behavioral case descriptions (e.g., Beck, 2011) focus on clients' skills, habitual thought patterns, and the stimuli that precede and follow problematic behaviors.

Regardless of theoretical orientation, a clinician's assessment outline will be broad enough to provide a general overview of that client yet focused enough to allow coverage of all the specific questions or collaborative assessment processes that the clinician wishes to address. The outline also guides production of the assessment reports that, as discussed at the end of this chapter, provide an organized presentation of assessment results. This is because, as we mentioned earlier, clinicians who adopt differing theoretical orientations tend to ask different assessment questions that are reflected in their assessment outlines. Here are two examples representing the psychodynamic and cognitive behavioral approaches to clinical psychology.

Psychodynamic Assessment Outline

Patient information

- Personal
- Demographic

Presenting problem(s)

History

- Attachment, early family relations
- Medical and psychiatric
- Interpersonal, social, cultural

Psychological testing

- Projective tests
- Objective tests

Mental status

DSM diagnosis

Ego strengths

Defense mechanisms

Relationship boundaries

Self-concept and self-esteem

Cognitive Behavioral Assessment Outline

Client information

- Personal
- Demographic

Presenting problem(s)

History of presenting problems, including precipitating factors

Client understanding of problems

Coping responses

- Behavioral
- Cognitive

Emotional
Relational

Psychiatric history

Family, social, educational history

Psychological testing

Objective

Daily activities

Mood

Work and social functioning

Client goals, motivation, and expectations of treatment

What about the assessment outlines of humanistic clinicians? Their case descriptions are less likely to focus on specific assessment questions, so their outlines may not be as formal as those seen in other approaches. For these clinicians, assessment is a collaborative process through which they try to understand how their clients perceive themselves and the world, so they may employ a variety of nontraditional assessment methods (e.g., Fischer, 2001; Gorske, 2008). In fact, some humanistically oriented clinicians have argued against the entire assessment process on the grounds that traditional testing, interviewing, and observational procedures are dehumanizing, take responsibility away from clients, and threaten the quality of the clinician–client relationship (Rogers, 1951). Others acknowledge the possibility that assessment data collected through traditional means can be

useful, but only if they are evaluated in line with humanistic principles (Fischer, 1989). For example, test results can be viewed as clues to how a client looks at the world, and conducting those tests can provide opportunities for the clinician and client to build their relationship (Dana & Leech, 1974). Constance Fischer (2001) has argued that assessments using standardized, empirically supported instruments can be both scientific and therapeutic when assessments are conducted interactively between therapist and client (see also Finn, 1996).

The Assessment Context. The choice of assessment methods is often substantially influenced by the contexts, or settings, in which assessments are conducted. Common settings include general medical and psychiatric facilities, private or community psychological clinics, jails, prisons, forensic (legal) situations, schools and other educational institutions, and the like. Each type of setting influences the nature of the referral questions asked, the kinds of assessment instruments expected or preferred, and the style of reporting that is most appropriate or most often requested (Groth-Marnat, 2009). For instance, clinicians unfamiliar with legal settings may initially find it disconcerting to have their clinical judgments, and even their professional qualifications, challenged. The language used in legal contexts is also different from that used in psychological contexts, and it is incumbent on the clinician to transform potentially obscure psychological terms into language that attorneys and judges can understand. Educational settings, too, bring with them their own preferred theories, terms, and methods of practice. So clinicians working in these settings must not only clarify the referral question before conducting the assessment; they must also select context-appropriate instruments and present their conclusions in ways that are the most useful to those who requested the assessment.

Cultural Factors. As you may recall from Chapter 1, Rachel Jackson's grandmother immigrated to the United States from Lithuania. Now 70 years old, Danutė Bagdonas (not her real name) has recently been experiencing episodes of confusion and forgetfulness and seems unusually withdrawn, leading Rachel's mother, Lena, to wonder if these might be early signs of Alzheimer's disease, or perhaps depression. When Lena expressed her concerns about these changes to Dr. Leon, the clinical psychologist she had consulted about Rachel's problems, Dr. Leon suggested that it might be a good idea for Mrs. Bagdonas to be tested for deficits in her cognitive capacities, and also to be evaluated by a clinical geropsychologist, a specialist in the assessment and treatment of older adult clients. Mrs. Bagdonas did not think that any of this was necessary, but she eventually agreed to participate in a testing session with Dr. Geoffrey Kramer (not his real name), a clinical neuropsychologist at the local community mental health center. As described in Chapter 11, she eventually agreed to see a geropsychologist, too.

It took no more than a few minutes for Dr. Kramer—a European American who speaks not a word of Lithuanian—to discover that Mrs. Bagdonas has quite limited English language skills. As he glanced at the standardized multi-page structured interview assessment form in his hands, and the many neuropsychological test forms on his desk, Dr. Kramer wondered if and how he should proceed.

What steps could and should have been taken ahead of time to make the situation less awkward and more productive? What should the goals of this assessment be and what assessment instruments would best accomplish them? Will the assessment instruments be understood by the client? Will the results be valid for their intended purposes?

Multicultural competence is increasingly necessary for mental health

professionals (Rosenberg, Almeida, & McDonald, 2012). With ever more diversity in the U.S. population, there is a much greater chance that clinicians will encounter clients whose cultural backgrounds and worldviews are significantly different from their own. In such cases, the initial challenge is quite basic: establish lines of communication and trust (Comas-Diaz, 2012). In the case example just described, even if the language barrier is overcome —either by hard work on the part of the participants or by referral to a clinician who speaks Lithuanian—there still may be problems related to trust. Members of minority groups may differ from other clients in their expectations and beliefs about the goals of assessment and the extent to which clinical interventions might help them. So clinicians must ensure that assessment goals are not socially or culturally biased in a way that would make the process less valid for minority clients (Mitchell, Patterson, & Boyd-Franklin, 2011).

A good deal of multicultural assessment research is devoted to exploring whether assessment instruments such as questionnaires, tests, and structured interviews, are equally valid for different populations. This research is important because differences in validity across groups are a form of bias, and many psychological assessments were developed and normed on U.S. samples. Using psychological tests that are not applicable to other groups—a finding that can only be established by careful cross-cultural research—may not only be inappropriate, but may lead to court decisions prohibiting their use for educational placement and other purposes (Lambert, 1985). When conducting assessments on clients from different cultures, clinicians must therefore be knowledgeable about how sociocultural factors can affect assessment results, not to mention diagnostic accuracy and the choice and

outcome of treatments (Lopez & Guarnaccia, 2000). We discuss cultural factors and cultural competencies in assessment further in Chapters 4 and 5.

Core Competencies in Assessment. There are so many types of assessments available that no clinician can be expected to have mastered them all. Still, every clinical psychologist should possess a set of core competencies in assessment. No single set of competencies has been universally agreed upon, but there are some similarities among the ones suggested by various professional organizations, employers, educational institutions, and clinical internship sites (Krishnamurthy et al., 2004). We have drawn upon those similarities to construct the list of competencies presented in Table 3.5. Notice that some of them relate to the empirical and theoretical foundations of assessment (e.g., an understanding of personality or cognitive variables that tests measure, an ability to judge reliability and validity), whereas others relate to the use of specific measures or assessment goals (e.g., interview formats, intellectual tests, personality tests, diagnostic assessment).

Table 3.5 A Summary of Core Competencies in Clinical Assessment

Clinical psychologists trained in assessment should be able to:
understand the theoretical, empirical, and contextual bases of assessment.
evaluate the psychometric properties of assessment instruments.
successfully administer and interpret instruments designed to assess cognitive functioning, behavioral functioning, and personality.
conduct and interpret clinical interviews and behavioral observations.

formulate appropriate *DSM* diagnoses.

recognize the limitations and appropriate uses of assessment instruments for special populations, such as cultural and linguistic groups, physically challenged individuals, and so on.

integrate data from multiple assessment sources into empirically grounded conclusions.

effectively communicate the results of assessments to others in written and spoken reports.

understand and follow APA Ethics Code guidelines for assessment.

In Review Factors Influencing the Choice of Assessment Instruments

Psychometric properties	**Reliability (consistency of measurement)** Test–retest Internal consistency (e.g., split-half) Interrater **Validity (accuracy of measurement)** *Construct validity* (e.g., does a test measure the construct of interest?) Subtypes include: *Content validity* (does a test address all the content related to a construct?). *Criterion validity*, including ability to predict events (predictive validity), give results similar to those from other measures of the same construct (concurrent validity) but different from those measuring different constructs (discriminant validity).
Standardization	Has a test or other assessment method been administered to a sample of people that is large enough and representative enough to establish clinically useful norms for interpreting a client's score on those assessments?
Bandwidth vs. fidelity (also called breadth vs. depth)	Given a fixed amount of time for assessment, instruments that measure in greater detail can cover fewer target areas; those that cover more areas can provide information that is less detailed.
Clinician experience	Clinicians tend to choose assessment

and theoretical orientation	instruments which were favored by their own professors, with which they are most comfortable, and which are consistent with their preferred theory of behavior and psychopathology.
Assessment context	Clinicians must choose assessment methods that are most appropriate for the setting in which the assessment is to take place.
Culture and diversity	Assessment methods may not be appropriate for use with people from sociocultural groups on which those methods have not been standardized. Awareness of the role of culture in assessment results is one of the core competencies in clinical assessment that clinicians should possess.

Test Yourself

1. A test that yields about the same score when taken by the same person 6 months apart is said to have ___________.

2. If people who are known to be anxious score high on a new test of anxiety, this would be evidence of the test's ___________.

3. A life history structured interview that focuses almost entirely on a client's high school years would be said to have ______ bandwidth and _____ fidelity.

You can find the answers in the Answer Key at the end of the book.

Clinical Judgment and Decision-Making

Section Preview Clinicians make judgments by combining information from different sources. In doing so, they can rely on empirically based methods of decision-making, on clinical experience and intuition, or on a combination of the two. You will see in this section that although clinical intuition can be valuable in some situations (as in moment-to-moment responses to clients during the course of therapy), research shows that clinical psychologists have no special intuitive capacity: they are prone to the same kinds of errors in judgment and decision-making that affect all humans when they rely on impressionistic thinking. Knowing this to be true, clinical scientists seek to incorporate into their judgments whatever guidance they can get from empirically based, actuarial models—including those based on artificial intelligence—whenever such models are available.

Whether a clinician is trying to assess the likelihood of a client attempting suicide, a stalker harming a victim, a child being abused by a parent, a brain-injured client succeeding in a new job, or a particular form of psychotherapy alleviating a sufferer’s anxiety, all predictions involve clinical judgments. How accurate are those judgments?

Clinical Intuition

As our discussion of the prediction of dangerousness suggests, research does not support the idea that clinicians have special inferential capabilities. Clinical psychologist Donald Peterson made this point forcefully more than 50 years ago: “The idea that clinicians have or can develop some special kinds of antennae with which they can detect otherwise subliminal interpersonal stimuli and read from these the intrapsychic condition of another person is a myth which ought to be demolished” (Peterson, 1968, p. 105). There is now a large body of research addressing the accuracy of clinical intuition. Some of this work has systematically compared the accuracy of experts’ clinical judgments about psychiatric diagnoses, suicide or violence risk, neuropsychological impairment, and psychotherapy outcome, with the accuracy of judgments made by nonexperts or by automated programs that analyze clinical assessment data using statistical models. The clear result is that clinical intuition does not usually lead to the most accurate judgments, and is all too often inferior to other methods of combining assessment information (Ægisdóttir et al., 2006; Goldberg, 1959; Grove et al. 2000; Hanson & Morton-Bourgon, 2009; Meehl, 1957, 1965; Spengler et al., 2009).

Clinicians Have Special Intuitive Powers? Bull
The mass media have long portrayed clinical psychologists as experts who can astutely translate obscure signs into accurate statements about a person's past, present, and future. This image is greatly exaggerated, but it remains alive and well in a number of TV series.

(Source: CBS Photo Archive/CBS/Getty Images.)

Why is it that, even after many years of training and experience, clinicians do not typically make better clinical judgments than nonexperts or artificial intelligence systems? As we already mentioned, because they are human, clinicians are prone to the same cognitive habits and biases that can lead to error in anyone else's information processing. For example, clinicians' judgments, like other humans' judgments, are more prone to error when they rely too heavily on rules of thumb or mental shortcuts known as **heuristics**. One of these shortcuts, known as the *availability heuristic*, stems from the fact that experiences that are recent or remarkable are especially available to recall. The bias associated with the availability heuristic can be seen in the results of publicity for lotteries. Photographs of ecstatic people

who won millions of dollars create the impression that these rare events occur more often than they really do, thus prompting falsely hopeful people to buy lottery tickets that, in all probability, will be worthless.

Heuristics
Mental shortcuts, or rules of thumb people use to help them make judgments and decisions.

In clinical situations, the availability heuristic may lead psychologists to overestimate the likelihood of psychological problems that they see often and that therefore come most easily to mind. The result may be overdiagnosis of those problems (Garb, 1998; Lilienfeld & Lynn, 2014). Even what they hear from other clinicians can affect their judgment. Memorable clinical "folklore" can create *illusory correlations* (Chapman & Chapman, 1967; Costello & Watts, 2019), the tendency to see an association between two variables when there is none. These false perceptions can cause clinicians to draw false inferences from assessment data (Krol, DeBruyn, & van den Bercken, 1995; Lewis, 1991). A classic example is provided by clinicians who infer paranoid tendencies in clients who draw large eyes on figure-drawing tests, even though research evidence shows the association between drawn eye size and paranoia to be weak or nonexistent (Golding & Rorer, 1972).

Clinicians also tend to display an *anchoring bias* in which—much as the rest of us form first impressions quickly—they let their view of a client's disorder be influenced more strongly by the first few pieces of assessment

information they receive than by any subsequent information (Tutin, 1993). Anchoring bias can also influence clinicians to allow assessment information from certain sources (e.g., a parent's report of a child's behavior) to outweigh information from all other sources (McCoy, 1976). The problem with anchoring bias is that we tend to cling too firmly to first impressions and do not make sufficient adjustments when new data warrant doing so. Anchoring bias is related to another cognitive error called *confirmation bias*, which refers to the tendency to seek out and interpret new information in line with existing beliefs (Nickerson, 1998). As a result of confirmation bias, the clinician may ignore contradictory evidence, discount its validity, or even distort it to fit initial impressions (Strohmer & Shivy, 1994; Youngstrom et al., 2015). Suppose, for example, that Dr. Leon suspects that Rachel Jackson's problems stem in part from being sexually abused in childhood even though there is no evidence to support her suspicion. If Dr. Leon were to be guided by this suspicion rather than objective evidence, she might interpret some aspects of Rachel's relationship with her father as confirming the suspicion. Rachel's breakup with her boyfriend, too, might then be seen in light of a background of abuse that may or may not exist.

Even the amount of assessment information available can lead to errors in clinical judgment. Numerous studies suggest that having larger amounts of assessment information tends to increase clinicians' confidence in the inferences they make, but does not necessarily improve the accuracy of those inferences (Einhorn & Hogarth, 1978; Garb, 1984; Kleinmuntz, 1984; Rock et al., 1987). In some cases, it may even decrease it (Dana, Dawes, & Peterson, 2013), so we should not assume that more assessment is always going to be better assessment. That's because additional pieces of information can contribute additional error; the less precise the new predictor,

the greater the error it contributes. Clinicians' judgments may also be prone to error because therapists misremember information or fail to collect all the important data they need. Finally, like everyone else, clinicians tend to remember their successes more vividly than their failures, and so may remain wedded to incorrect assessment practices or diagnostic preferences simply because they recall the times those practices or preferences worked more than the times they didn't (Garb, 1989). Indeed, clinicians often don't receive accurate feedback about their successes and failures. This situation is problematic because prompt and accurate feedback is essential for learning from our mistakes, which in turn is essential for acquiring expertise (Kahneman & Klein, 2009).

Clinical and Statistical Prediction. The sobering body of research we have just reviewed has led some clinical scientists to ask whether clinical predictions would be more accurate if they were based upon formal, statistical data-processing methods rather than on informal methods that depend on expert clinical judgment. **Statistical prediction** (also called *actuarial prediction* or *mechanical prediction*) involves inferences based on probability data and formal procedures for combining information, all derived from research. **Clinical prediction**, as we have seen, involves inferences based primarily on a practitioner's intuitions, informal observations, assumptions, and professional experiences. Which is better? A large body of research has addressed this question by comparing clinical and statistical prediction head to head.

Statistical prediction

Drawing clinical inferences based on probability data and formal procedures for combining information.

Clinical prediction

Drawing clinical inferences based primarily on intuition, informal observations, assumptions, and experience.

The first example of this kind of research appeared in 1954, when Paul Meehl published his now-classic review of 20 studies comparing formal versus informal inference methods. He found that, in all but one case, the accuracy of the statistical approach equaled or surpassed that of the clinical approach. Later, even the sole exception to this surprising conclusion was called a tie, and as additional research became available, the general superiority of the statistical method of prediction was more firmly established (Dawes, Faust, & Meehl, 1989; Meehl, 1957, 1965). At its worst, the statistical method does about as well as clinical prediction; as Meehl noted, even that finding is effectively a "win" for the statistical method given that, once developed, it is far more efficient and cost-effective to use than the clinical method.

In the years since Meehl's review, numerous published responses have appeared, many of which pointed out methodological defects in some of the studies that could have biased results in favor of statistical procedures.

Frederick C. Thorne (1972) put it this way: “The question must not be what naïve judges do with inappropriate tasks under questionable conditions of comparability with actual clinical situations, but what the most sophisticated judges can do with appropriate methods under ideal conditions” (p. 44). Yet studies have shown that even when clinicians are given access to information that they typically receive, such as interview impressions, the gap between statistical and clinical prediction remains (Grove, 2005). Moreover, the furor over Meehl’s conclusions could not negate the fact that inference based on subjective, clinical methods is not as accurate as it was assumed to be, even on many clinically relevant tasks (Dawes, 1994; Hanson & Morton-Bourgon, 2009).

The strongest evidence for this assertion comes from meta-analyses. For example, William Grove and his colleagues (Grove et al., 2000) looked at 136 studies in which psychologists predicted criteria within their areas of expertise, including psychotherapy outcome, future criminal behavior, fitness for military service, marital satisfaction, psychiatric diagnoses, success on psychology internships, and several others. The results of their meta-analysis were striking, and consistent with those of previous studies: Statistical/mechanical prediction outperformed clinical prediction overall, regardless of the type of judges, the judges’ experience, the type of data being combined, or the design of the study. The advantage for statistical prediction wasn’t large—roughly 10% on average—and in many studies the accuracy of clinical and statistical prediction were about the same. In the small percentage of studies in which clinical prediction slightly outperformed statistical prediction, the authors found no pattern of variables that reliably distinguished when or why clinical prediction was superior. Similar results emerged in two other meta-analyses, one that examined judgments in a

variety of domains, and another that examined predictions of recidivism (reoffending) among 45,398 sexual offenders (Ægisdóttir et al., 2006; Hanson & Morton-Bourgon, 2009). Both found an edge for statistical prediction, though the difference in accuracy was not large, only about 10–20%, and it varied by type of prediction. For example, statistical models more clearly outperformed clinical prediction when forecasts involved dangerousness (Hilton, Harris, & Rice, 2006). There were also differences across settings, types of statistical formulas used, and amount of information available to clinicians.

In short, there is considerable evidence that too few clinicians appreciate the limits of clinical intuition. This oversight makes them vulnerable to criticisms from within and outside their profession (Faust & Ziskin, 1988; Ridley & Shaw-Ridley, 2009; Tavris & Aronson, 2007). Years ago, Frederick Thorne (1972) suggested that "clinicians must become much more critical of the types of judgments they attempt to make, the selection of cues upon which judgments are based, and their modes of collecting and combining data" (p. 44). That statement still applies today. Based on years of research on the issue of statistical versus clinical prediction, the following conclusions seem reasonable:

1. Statistical/actuarial prediction generally, though modestly, outperforms clinical prediction. At worst, the two are about equal.

2. The superiority of statistical prediction is most evident in predicting violence and other rare events.

3. Practicing clinicians typically underutilize and undervalue actuarial prediction methods.

Improving Clinical Judgment

Some psychologists have argued that, even if it is superior to human clinical judgment, mechanical decision-making dehumanizes patients by reducing them to a set of numbers. Yet, if one takes a broader view, the generally superior performance of actuarial models, particularly for rare events such as violence, is by no means a sign of professional failure. We don’t denigrate meteorologists or stockbrokers when they rely on statistical models and computer-generated forecasting, nor do we distrust physicians who refer to databases and formal decision models to help them diagnose medical conditions. Indeed, we suspect that most patients appreciate the thoroughness and professionalism of physicians who take advantage of the latest research and technology in reaching a diagnosis. Such techniques are hardly dehumanizing; to the contrary, they humanize and empower patients by providing them with information regarding the best possible care, and the best research-based options for that care. Consider, too, that a great deal of clinical experience and research typically goes into the development of useful actuarial models for clinical judgment, and that clinical scientists have always relied on research to separate the wheat from the chaff in evaluating their favored theories. So clinical psychologists continue to play an essential role in improving clinical judgment, not only by carefully collecting the interview, test, and observational data to be fed into actuarial formulas, but also by generating potentially fruitful hypotheses regarding new variables to measure.

Remember, too, that clinical judgment is not invariably wrong. With more years of experience, clinicians’ judgments tend to improve to a certain

extent. For example, Peter Spengler and his colleagues (2009) conducted a meta-analysis of 75 judgment studies involving 4,607 clinicians and found that their accuracy increased by about 13% with experience, regardless of other factors. These findings are only correlational, so as with all correlations, they can't confirm that greater accuracy was a result of more experience. The slightly positive correlation between years of experience and accuracy results could also reflect a trend in which clinicians who make the best predictions are the most successful and thus stay in the profession longer than those who don't do as well. Still, it seems plausible that using a certain amount of experience-based intuition, combined with accurate and timely feedback about the accuracy of predictions, could contribute to enhanced predictive capacity (Kahneman & Klein, 2009).

Having more experience may also be associated with having more time to learn about research on clinical decision processes, including the numerous factors that can bias clinical judgment, which in turn may make clinicians less vulnerable to them. Indeed, our discussion here suggests that clinical psychologists should be guided by the extensive research literature on clinical judgment and on clinical versus statistical prediction. What determines whether clinicians incorporate statistical models in their clinical decisions? A survey of 491 members of the American Psychological Association's Division 12 (Clinical Psychology) found that some of them dismissed research on clinical judgment as conceptually misguided or irrelevant to real decisions (Vrieze & Grove, 2009). This attitude reflects an overgeneralization that, given the diversity of studies, risks "throwing the baby out with the bath water." However, the main factor that determined whether clinicians used statistical models in their clinical decisions was the extent to which that topic,

and the research associated with it, was discussed when they were in graduate school.

With such results in mind, a number of clinical psychologists have offered proposals to make clinical reasoning a more explicit, rather than implicit, part of training. The goal would be to teach clinicians-in-training to avoid the most common errors in clinical judgment and prediction (Ridley & Shaw-Ridley, 2009; Spengler et al., 2009). By most counts, this change is sorely needed. In a now somewhat dated survey of accredited clinical psychology training programs, issues related to decision-making were more likely to be covered in elective courses, such as cognitive psychology, than in required courses; only 9% of programs required courses that contained a significant component on decision-making (Harding, 2007). We don't know if this state of affairs has improved since that survey was conducted, but we hope so.

In Review Clinical Judgment and Decision-Making

Cognitive factors potentially impairing the accuracy of intuitive judgment and decision-making	Availability heuristic, illusory correlations, anchoring bias, confirmation bias.
Clinical vs. statistical prediction	Though clinicians often rely on their clinical intuition in making judgments, decisions, and predictions, meta-analyses suggest that it is usually no better than what statistical models produce, and often not as good.
Improving clinical judgment	Better clinical judgment is modestly associated with longer clinical experience, but more substantial improvement is likely to result from training programs that focus on using statistical models and being aware of cognitive biases.

Test Yourself

1. Clinicians who rely mainly on their intuition to predict clients' responsiveness to psychotherapy have greater confidence in the value of ______ than in the value of _________.

2. The most accurate clinical judgments are likely to arise when clinicians collect ________ and then use _________ to make __________.

3. Giving more weight to information that is consistent with a clinician's initial impression of a client is an example of __________.

You can find the answers in the Answer Key at the end of the book.

Communicating Assessment Results

Section Preview Assessment results are communicated in an assessment report. In this section, you will see that assessment reports should be clear, relevant to the goals of the assessment, and conveyed using language that will make them maximally useful to the consumers of the report.

If assessment results are to have maximum value, they must be presented in reports that are clear, relevant to the assessment goals, and useful to the intended consumer. Accordingly, clinicians must guard against problems that can make reports vague, irrelevant, and useless. Table 3.6 illustrates how an assessment outline—in this case, a cognitive behavioral outline—is translated into an assessment report. Notice that it is sufficiently problem-oriented to be used with clients seeking help, while reminding the clinician to consider broader and less problematic aspects of a person's life.

Table 3.6 An Assessment Report Based on a Cognitive Behavioral Outline

Behavior During Interview and Physical Description
Phil is a 20-year-old college student. At the first interview, he seemed shy, soft spoken, and uncomfortable about seeking therapy. Still, he seemed willing and able to describe his problems and his feelings. *Presenting Problem:* A. *Nature of problem:* Anxiety in social situations, especially those involving public speaking, in which he feels that others are evaluating him. B. *History:* Phil reports "always" being shy when in social situations and

overly concerned with performance. He attributes the latter problem to his father, whom he describes as harshly critical of him and who would "grade" the quality of his homework before he turned it in and would sometimes make him redo it until it met his exacting standards. He described his mother, too, as overly controlling, although more overtly affectionate than his father. Both parents compared him unfavorably to his younger brother, who was always a good student.

C. *Specific problematic situations:* Interaction with his parents, academic examinations, family gatherings, class discussions, meeting new people.

D. *Cognitive factors:* Phil's descriptions suggest that he has adopted unreasonably high standards, expecting himself to achieve perfection in academic and social situations, and believing that he must attain approval from everyone to be worthwhile.

E. *Dimensions of problem:* The patient's social and evaluative anxiety are longstanding and occur in a wide variety of day-to-day situations.

F. *Consequences of problem:* In addition to creating social isolation and underperformance in academic exams, Phil's anxiety may be related to a history of gastrointestinal distress that requires him to take antacids on a regular basis.

Other Problems:

A. *Assertiveness*. Although obviously shy, Phil said that lack of assertiveness is no longer a problem for him. He feels that he can stand up for himself better now than in the past, but this is something to explore further to determine if his assertiveness skills are helping him to achieve his goals.

B. *Forgetfulness:* Phil describes himself as "scatterbrained" because he often forgets appointments, loses keys and other items, and even misses exams. Further evaluation is needed to determine whether this self-critical

judgment reflects an unusual level of forgetfulness, which may follow from deficits in certain organizational skills, or from a tendency to have unusually high standards and self-critical thinking.

Personal Strengths:

Phil is intelligent, and appeared in the interview to be sensitive, friendly, and to have a good sense of humor.

Targets for Treatment:

Irrational expectations and self-statements in social-evaluative situations; possibly assertiveness.

Recommended Treatment Approach:

Cognitive restructuring, role-playing, and homework assignments to practice new, less self-critical thinking, and practice entering social situations that provoke some distress to learn that he can tolerate the distress and that feared outcomes do not typically occur.

Motivation for Treatment:

High.

Prognosis:

Very good.

Priority for Treatment:

High.

Client's Expectancies:

Phil says he wants to learn to eliminate his anxiety, and it appears that he is

sincere about this. He will probably be cooperative with the treatment plan.

Report Clarity

The first criterion of a high-quality assessment report is clarity. Without this attribute, relevance and usefulness cannot be evaluated. Lack of clarity in psychological reports is troublesome because misinterpretation of a report can lead to misguided decisions. Here is a case in point:

> *A young girl, [intellectually disabled], was seen for testing by the psychologist, who reported to the social agency that the girl's test performance indicated moderate success and happiness for her in "doing things with her hands." Three months later, however, the social agency reported to the psychologist that the girl was not responding well. Although the social agency had followed the psychologist's recommendation, the girl was neither happy nor successful doing things with her hands. When the psychologist inquired what kinds of things, specifically, the girl had been given to do, he was told "We gave her music lessons—on the saxophone."*
>
> (Hammond & Allen, 1953, p. v)

A related problem exists when the assessor uses jargon that may be meaningless to the reader. Consider the following excerpt from a report on a 36-year-old man:

> *Test results emphasize a basically characterological problem with currently hysteroid defenses. Impairment of his ability to make adequate use of independent and creative fantasy, associated with emotional lability and naïvete, are characteristic of him. Due to markedly passive-aggressive character make up, in which the infantile dependency needs*

> *are continually warring with his hostile tendencies, it is not difficult to understand this current conflict over sexual expression.*
>
> (Mischel, 1968, p. 105)

The writer may understand the client, but will the reader understand the writer? Anyone not well versed in psychoanalytic terminology would find such a report mystifying. Even professionals may not agree on the meaning of the terms employed. Factors such as excessive length (or cryptic brevity), excessively technical information (statistics or esoteric test scores), and lack of coherent organization also contribute to lack of clarity in assessment reports (Olive, 1972; Wright, 2011).

Relevance to Goals

Although far less common today than in the past, clinicians may still be asked for “psychologicals” (usually a standard test battery and interview) without being told why the assessment is being done. Under such circumstances, the chances of writing a relevant report are minimal. In other cases, a report’s lack of relevance is due mainly to the clinician’s failure to keep established assessment objectives in mind.

Usefulness of Reports

One must also ask if an assessment report is useful. Does the information have what Lee Sechrest (1963) called **incremental validity**—the ability to add something important to what we already know about the client? Reports that present clear, relevant information that is already available through other sources may appear useful but have little real value. Such reports tend to be written when the clinician has either failed to collect new information or has not made useful statements about new data. For example, a clinician may use psychological tests to conclude that a client has strong hostile tendencies, but if police records show that the client repeatedly has been arrested for assault, this conclusion doesn't add much to the clinical picture. In other instances, the assessor's report may have limited usefulness because it says nothing beyond what would be expected on the basis of base-rate information, past experience, and common sense.

Incremental validity
The ability of an assessment report to add something important to what is already known about a client.

Consider the following edited version of a report written entirely on the basis of two pieces of information: (a) the client is a new admission to a Veterans Administration (VA) hospital; and (b) the case was to be discussed at a convention session entitled "A Case Study of Schizophrenia."

This veteran approached the testing situation with some reluctance. He was cooperative with the clinician but mildly evasive on some of the material. Both the tests and the past history suggest considerable inadequacy in interpersonal relations, particularly with members of his family. It is doubtful whether he has ever had very many close relationships with anyone. He has never been able to sink his roots deeply. He is immature, egocentric, and irritable, and often he misperceives the good intentions of the people around him. He tends to be basically passive and dependent, though there are occasional periods of resistance and rebellion against others. Vocationally, his adjustment has been very poor. Mostly he has drifted from one job to another. His interests are shallow, and he tends to have poor motivation for his work. Also, he has had a hard time keeping his jobs because of difficulty in getting along with fellow employees. Although he has had some relations with women, his sex life has been unsatisfactory to him. At present, he is mildly depressed. His intelligence is close to average, but he is functioning below his potential. Test results and case history suggest the diagnosis of schizophrenic reaction, chronic undifferentiated type. Prognosis for response to treatment appears to be poor.

(Sundberg, Tyler, & Taplin, 1973, pp. 577–579)

Knowledge of VA hospital residents and familiarity with hospital procedures allowed the clinician to generate this impressive but utterly generic report without actually seeing the client. The case was to be discussed at a meeting on schizophrenia, and because schizophrenia diagnoses are common for VA residents, it was easy to surmise the correct diagnosis. Also, because it fits the "average" VA resident, the report was likely to be at least partially accurate. This bogus document exemplifies a feature of assessment

reports that reduces their usefulness: overgenerality, or the tendency to use terms that are so ambiguous they can be true of almost anyone. Documents laden with overly general statements have been variously dubbed “Barnum reports” (in honor of circus impresario P. T. Barnum’s boast that he liked to give “a little something to everyone” in his shows), “Aunt Fanny reports” (because the statements could also be true of “my Aunt Fanny”), or “Madison Avenue reports” (given that they “sell” well) (Klopfer, 1983; Meehl, 1956; Tallent, 1992). Such overly general material has the dual disadvantages of spuriously increasing the impressiveness of a report while decreasing its usefulness.

In Review Communicating Assessment Results

Criteria for valuable assessment reports	Clarity. Relevance to assessment goals. Usefulness to the consumer.
Framework for assessment reports	The clinician’s assessment outline.
Characteristics of clear assessment reports	Unambiguous wording. Absence of jargon.
Primary characteristic of useful assessment reports	Provides new information that addresses a relevant question.

Test Yourself

1. Assessment reports cannot be useful if they are not _________.

2. The contents of an assessment report usually reflect the clinician’s _____ and _______.

3. If an assessment report provides no information beyond what the report consumer already knows about the client, it is low on ________.

You can find the answers in the Answer Key at the end of the book.

Ethical Considerations in Assessment

Section Preview In this section, you will learn about some of the ethical issues that confront clinicians who perform assessments, especially when they become embroiled in bitter divorce or child custody cases, when they help to determine whether clients are eligible for disability based on mental illness, or when they must decide what information to reveal about a client to third-party payers such as insurance companies. You will see that clinicians must know the limitations of the assessments they perform, and they must be clear in advance about how those assessments are to be used. They should also be knowledgeable about how federal and state laws and the APA Ethical Principles of Psychologists and Code of Conduct govern their assessment activities.

The process of collecting, processing, and communicating assessment data obviously gives clinicians access to sensitive information that the client might not normally reveal. Having this access places a heavy responsibility on the clinician to use and report this privileged information in a fashion that safeguards the client's welfare and dignity. This responsibility includes being concerned about (a) how psychological assessment data are being used; (b) who should have access to confidential material; and (c) the possibility that improper or irresponsible interpretation of assessment information will result in negative consequences for clients.

With these concerns in mind, clinicians must first be sure that their inquiries do not constitute an unauthorized invasion of a client's privacy. This is a particularly tricky problem because they do not always know who

might gain access to assessment information once that information is transmitted to a referral source. When test scores, conclusions, predictions, and other information are communicated in a report, they may be misused by people who are not qualified to interpret that report. In such cases, not only is the client's privacy invaded, but the assessment data may create harmful outcomes for the client. Minimizing these problems is a major concern of public officials, government agencies, citizens' groups, and private individuals.

Clinicians' assessment practices are guided by the American Psychological Association's *Ethical Principles of Psychologists and Code of Conduct* (American Psychological Association, 2017a), particularly Section 9, which deals with assessment. The APA also offers *Guidelines for Psychological Evaluations in Child Protection Matters* (American Psychological Association, 1998), *General Guidelines for Providers of Psychological Services* (American Psychological Association, 1987), and *Standards for Educational and Psychological Testing* (American Psychological Association, 1985). These guidelines reflect federal legislation, including the Equal Employment Opportunity Act (part of the Civil Rights Act of 1964), which prohibits the use of tests that have an adverse impact on the selection of minority group job candidates, and the Civil Rights Act of 1991, which bans the adjustment of test scores on the basis of race, color, religion, sex, or national origin (Sackett & Wilk, 1994). The guidelines must also be implemented in accordance with the regulations of the Individuals with Disabilities Education Act and the Americans with Disabilities Act.

Clinicians must also take care to ensure that assessment goals are not socially or culturally biased such that certain clients, including members of ethnic or racial minorities, are placed at a disadvantage (Malgady, 1996). For

example, some psychological tests are alleged to be inappropriate for use with minority groups, leading to court decisions prohibiting their use for educational placement and other purposes. So, as in the case of Danutė Bagdonas, when clinicians conduct assessments with clients from cultures that are different from their own, they must be aware that sociocultural factors can affect diagnosis, assessment, and treatment (Lopez & Guarnaccia, 2000).

Ethical guidelines for assessment are often just that—guidelines; they may not clearly tell psychologists what they should or should not do in a particular case. In such situations clinicians typically consult with colleagues and seek guidance from the American Psychological Association about the best course of action. Ethical decision-making also involves taking into account various federal, state, and local laws. You can read more about the ethical problems and ethical standards associated with clinical psychology in Chapter 15.

Chapter Summary

Clinical assessment is the process of collecting information to be used as the basis for informed decisions by clinicians or by those to whom results are communicated. Interviews, tests, observations, and life records serve as the main sources of assessment data in clinical psychology. The clinical assessment process includes five stages: clarifying the referral, planning data collection, collecting data, processing data, and communicating results. The methods and levels of inquiry in assessment tend to follow a case study guide shaped by assessment goals, clinicians' theoretical preferences and experience, and situational contexts. Selection of assessment methods is also guided by research on their reliability (consistency) and validity (ability to measure what they are supposed to measure), and depth versus breadth.

The goals of clinical assessment typically involve diagnosis, description, treatment planning, and prediction. Diagnostic decisions normally employ the *DSM* or *ICD*. Description involves broader assessments of clients' personalities and functioning by looking at person–environment interactions. Assessment for treatment planning involves collecting information about how clients might respond to various treatment approaches. Predictions often involve personnel selection, but sometimes focus on a client's potential for violence or suicide.

Because clinicians have no unique intuitive powers or special information-processing capacity, the quality of their judgments and decisions about clients can be threatened by the same cognitive biases that afflict all human beings. Indeed, research on clinical judgment suggests that in many

situations, clinicians can make their greatest contribution to assessment as developers of measures and collectors of information that is then processed by computer-based statistical formulae.

Assessments are driven primarily by the assessment goals, but other factors can also influence how assessments are conducted. The reliability, validity, and generality of assessment instruments should play an important role in a clinician's selection. The clinician's theoretical orientation and prior experience with instruments affect assessment choices, too, as does the context in which assessments are made (e.g., legal, educational, psychiatric hospital, psychological clinic).

The results of clinical assessment are often presented in an organized assessment report, which should be clear, relevant to the goals of assessment, and useful to the intended consumers. These reports often reflect the theoretical approach taken by each clinician, but they should be constructed in a way that is based on the best available scientific information, maximally useful to the referral source, and consistent with ethical practices.

4

Interviewing and Observation in Clinical Psychology

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Contents

Clinical Interview Situations

Interview Structure

Stages in the Interview

Evaluating the Quality of Interviews

Observational Assessment

Approaches to Observational Assessment

Research on Observational Assessment

Chapter Preview

In this chapter, we describe a variety of interview and observation techniques. We begin with interviews, categorized first by their goals and then by their structure. We also address stages of the interview process and what research has revealed about the reliability and validity of differing types of interviews. We treat clinical observations in much the same manner, discussing their goals and types as well as research on their strengths and limitations. Throughout, we discuss how various factors—particularly interview and observation structure, client diversity, and clinicians' biases—can affect the results of interviews and observations.

Interviews and observations are the most widely employed tools in clinical psychology. They are central to clinical assessment and play prominent roles in psychological treatment. Indeed, much of what we have to say in this chapter about interviews and observations also applies to treatment because treatment usually begins with—and is based on—the relationship established through the interview process.

In simplest terms, an **interview** is a conversation with a purpose or goal (Matarazzo, 1965). Because interviews resemble other forms of conversation, they are a natural source of clinical information about clients, an easy means of communicating with them, and a convenient context for attempting to help them. Interviews are flexible, relatively inexpensive, and, perhaps most important, provide the clinician with simultaneous samples of clients' verbal and nonverbal behavior. These advantages make the interview useful in a variety of clinical situations.

Interview

A conversation with a purpose or goal

In this chapter, we will not try to teach you how to conduct specific types of interviews or observations; instead, we offer an introduction to interviews and observations as sources of assessment data. Interview and observation techniques for various situations are detailed in a number of sources (e.g., Cormier, Nurius, & Osborn, 2012; Craig, 2009; Hersen & Beidel, 2012; MacKinnon, Michels, & Buckley, 2009; Othmer & Othmer, 2002; Rogers, 2001; Saklofske, Schwean, & Reynolds, 2013; Segal, Mueller, & Coolidge, 2012; Shea, 2016; Sommers-Flanagan & Sommers-Flanagan, 2008). However, learning how to use these techniques effectively requires more than reading (Bogels, 1994): Clinicians must also engage in carefully supervised interview practice as part of their professional training.

Clinical Interview Situations

Section Preview There are interviews for a variety of clinical situations: intake interviews to establish the nature of someone's problems and assign a *DSM* diagnosis; orientation interviews to prepare a client for treatment or research, problem-referral interviews to address a specific referral question; termination or debriefing interviews to end treatment or research; and crisis intervention interviews to offer support and guidance during and following a crisis. Although we address these purposes separately, they often overlap in practice. We also discuss cultural or ethnic differences between interviewer and interviewee and the importance of interviewer responsiveness to cultural factors.

Intake Interviews

The most common type of clinical interview occurs when a client comes to the clinician because of one or more problems in living. **Intake interviews** are designed mainly to establish the nature of the problem, often called the presenting problem. Typically, intake interviewers are asked to describe the problem in terms of a *DSM* or *ICD* diagnosis (e.g., major depressive disorder). Information gathered in an intake interview may also help the clinician decide whether the client has come to the right place. If, on the basis of one or more intake interviews, the answer to that question is no, the clinician will commonly refer the client to another professional or agency for alternative services. If further contact is seen as desirable, additional assessment or treatment sessions are scheduled. Most clinicians conduct their own intake interviews, but in some agencies and group practices, social workers or other mental health professionals perform this function.

Intake interviews

Procedures designed to establish the nature of clinical problems.

An Intake Interview

Though often aimed at diagnosing disorders, intake interviewers may also be asked to develop broader descriptions of clients and the environmental context in which their behavior occurs.

(Source: SDI Productions/E+/Getty Images.)

Some intake interviews are organized according to a sequence of important topics suggested by the case study outlines described in Chapter 3. Originally patterned after the question-and-answer format of medical history-taking, many intake interviews also include a **mental status examination** (MSE), a planned sequence of questions designed to assess a client's mental

functioning in a number of important areas (see Table 4.1). The MSE is analogous to the physical examination that makes up part of the assessment of medical problems.

Table 4.1 The Mental Status Examination

Here is a typical MSE topic outline (Siassi, 1984), followed by a short excerpt from an MSE interview:

i. General appearance and behavior: Client's level of activity, reaction to interviewer, grooming and clothing are assessed.

ii. Speech and thought: Is client's speech coherent and understandable? Is there evidence of delusions (i.e., fixed false beliefs not shared by others in the client's culture)?

iii. Consciousness: Are the senses clear or clouded?

iv. Mood and affect: Is the client depressed, anxious, restless? Is his or her affect appropriate to the situation?

v. Perception: Does the client experience hallucinations (false sensory experiences) or depersonalization?

vi. Obsessions and compulsions: Amount and quality of these behaviors are noted.

vii. Orientation: Is client aware of the correct time, place, and personal identity?

viii. Memory: What is the condition of the client's short-term and long-term memory?

ix. Attention and concentration: Asking client to count backwards from

100 by 7s is a common strategy.

x. Fund of general information: Questions like “Who is the President?” or “What are some big cities in the United States?” are asked.

xi. Intelligence: Estimated from educational achievement, reasoning ability, and fund of information.

xii. Insight and judgment: Does the client understand probable outcomes of behavior?

xiii. Higher intellectual functioning: How coherent is the client’s thinking? Is the client able to deal with abstraction?

Clinician: Good morning. What is your name?

Client: Randolph S.

Clinician: Well, Mr. S., I would like to ask you some questions this morning. Is that all right?

Client: Fine.

Clinician: How long have you been here?

Client: Since yesterday morning.

Clinician: Why are you here?

Client: I don’t know. I think my wife called the police and here I am.

Clinician: Well, what did you do to make her call the police?

Client: I don’t know.

Clinician: What day is today?

Client: Tuesday, the twelfth. (correct answer)

Clinician: What year is it?

Client: 2019. (correct answer)

Clinician: What city are we in?

Client: Chicago. (correct answer)

Clinician: Who is the mayor of Chicago?

Mental status examination
A planned sequence of questions designed to assess a client's mental functioning in a number of important areas.

Intake interviews may also lay the groundwork for therapy efforts by establishing a productive working relationship and organizing the clinician's hypotheses about the origins and development of the client's problems (MacKinnon, Michels, & Buckley, 2009). A well-conducted intake interview is important to successful treatment because almost half the clients who attend an intake interview don't return for scheduled treatment (Morton, 1995). The clients' initial perception of their intake interviewer appears to affect this pattern. Clients are more likely to return for subsequent treatment after talking to an interviewer whom they feel treated them with warm friendliness as opposed to businesslike professionalism, who expressed

correct understandings of their concerns, whose nonverbal behaviors (e.g., facial expressions) were well matched to the clients' nonverbal behaviors, and whose social and cultural backgrounds were similar (Dimatteo & Taranta, 1976; Patterson, 1989; Rasting & Beutel, 2005; Rosen et al., 2012; Tryon, 1990). In some clinical situations, one psychologist conducts the initial intake interview and a different one begins psychotherapy at the next session. This switching of personnel can be problematic even when clients know about it beforehand. In fact, one study revealed that clients who experienced this kind of therapist discontinuity were twice as likely to terminate therapy by missing the first treatment appointment (Nielsen et al., 2009).

Problem-Referral Interviews

Clinicians sometimes serve as diagnostic consultants to physicians, psychiatrists, courts, schools, employers, social service agencies, and other organizations. In these circumstances, the client is often referred in order to answer a specific question, such as *Is Mr. P. competent to stand trial? Is Jimmy G. intellectually disabled?* or *Will such-and-such a custody arrangement with Ms. M. and Mr. O be in the best interest of this child?*

In these circumstances, the central goal of the **problem-referral** interview is to address the referral question. For this reason, referral questions must be stated clearly. Questions such as *Give me a profile of Mr. Q,* or *Will Ms. Y. make a good parent?*, or *Is she disturbed?* are too general or vague. And referral requests such as *Please test my child's IQ so I can prove to the school that he should be in the gifted class* should raise red flags about the ethical appropriateness of conducting the assessment without further clarification of the parent's motives and needs. As discussed in Chapter 3, the referral question, once clarified, largely determines the type of assessment conducted.

Problem-referral interview

A procedure designed to answer a specific referral question.

Orientation Interviews

People receiving psychological assessment or treatment often do not know what to expect, let alone what is expected of them. This is especially true if they have had no previous contact with mental health professionals. To make these new experiences less mysterious and more comfortable, many clinicians conduct special interviews (or reserve segments of interviews) to acquaint their clients with the assessment or treatment procedures to come (Prochaska & Norcross, 1994).

Such **orientation interviews** are beneficial in at least two ways. First, because the client is encouraged to ask questions and make comments, misconceptions that might impede treatment progress can be discussed and corrected. Second, orientation interviews can help clients understand upcoming assessment and treatment procedures and what their role in these procedures will be (Couch, 1995). Thus, the clinician might point out that the clients who benefit most from treatment are those who are candid, cooperative, serious, and willing to work to solve their problems. Good orientation interviews, then, can help focus clinicians’ efforts on those clients who are most willing to be full partners in the assessment or treatment enterprise.

Orientation interview

A procedure designed to acquaint clients with upcoming assessment, treatment, or research procedures.

Orientation interviews are also important for research participants. Although clinicians or researchers might not want to reveal every detail of the research design so as to avoid biasing participants, they are ethically required to ensure that each participant understands the nature of the tasks to be performed and any risks associated with them. Research orientation interviews not only satisfy the requirement for informed consent, but they also help ensure motivated cooperation from the participants, something especially important in long-term clinical trials and longitudinal research.

Debriefing and Termination Interviews

Debriefing interviews, designed to provide clients with information and assess their understanding of that information after an event, can occur in a number of situations. For example, people who have just completed a series of assessment sessions involving extensive interviews, tests, and observations are understandably anxious to know "what the doctor found," how the information will be used, and who will have access to it. These concerns are particularly acute when the assessor has acted as consultant to a school or a court. A debriefing interview can help alleviate clients' anxiety about the assessment enterprise by explaining the procedures and protections involved in the transmission of privileged information and by providing a summary and interpretation of the assessment results. Debriefing interviews can also occur with soldiers following battlefield experiences (Adler et al., 2009), with clients who have attempted suicide or self-injury (Kleespies et al., 2011a), or with clinicians in training following realistic simulation exercises (Morse, 2012). In all these situations, debriefings can help people who have experienced a significant event better understand it, ideally ensuring that potential gains are maximized and potential harms minimized.

Debriefing interview

A procedure designed to provide clients with information and assess their understanding of a just-completed event.

As their name suggests, **termination interviews** occur when it is time to end a clinical relationship. When psychological treatment has ended successfully, many loose ends must be tied up: There is gratitude to be expressed and accepted, reminders to be given about the handling of future problems, plans to be made for follow-up contacts, and reassurance given to clients about their ability to go it alone. Termination interviews help make the transition from treatment to posttreatment as smooth and productive as possible. When treatment is less successful, as when clients drop out early, termination interviews can inform clinicians or researchers about the dynamics leading to dropout and suggest ways to more effectively structure treatment in the future (Hummelen, Wilberg, & Karterud, 2007; Rosen et al., 2012).

Termination interview
A procedure designed to smoothly conclude a program of therapy or research.

Debriefing and termination interviews can also occur following participation in research. Typically, the debriefing of research participants involves providing them with additional information about the study, but sometimes researchers may interview participants to better understand how various aspects of the study were perceived. Such debriefing is especially essential in cases in which a study entails deception, as participants should always be informed that they were deceived.

Crisis Interviews

When people in crisis appear at clinical facilities or call a hotline, suicide prevention center, or other agency, interviewers do not have the luxury of scheduling a series of assessment and treatment sessions. Instead, they conduct **crisis interviews** in which they attempt to provide support, collect assessment data, and offer help, all in a very short time (Sommers-Flanagan & Sommers-Flanagan, 2008).

> **Crisis interview**
> A procedure designed to provide support, collect assessment data, and offer help to troubled clients, all in a very short time.

The interviewer must deal with the client in a calm and accepting fashion, ask relevant questions (e.g., “Have you ever tried to kill yourself?” “What kinds of pills do you have in the house?”), and work on the immediate problem directly or put the client in touch with other services. One or two well-handled interviews during a crisis may be the beginning and the end of contact with a client whose need for assistance was temporary and situation-specific. For others, the crisis interview leads to subsequent assessment and treatment sessions.

Ethnic and Cultural Issues in Clinical Interviews

As the U.S. population becomes increasingly diverse, the number of people from different ethnic and cultural backgrounds seeking mental health treatment increases (Li, Jenkins, & Grewal, 2012; Sue & Sue, 2007). Cultural differences between clients and interviewers require sensitivity, particularly when clients' cultural assumptions, values, and practices do not fit well with those of the mental health services offered.

Underutilization of Mental Health Care. The importance of cultural factors is highlighted by mental health utilization rates. Members of racial and ethnic minority groups generally receive less mental health care and lower-quality mental health care than does the general population (Hunt et al., 2015; Nevid, Rathus, & Greene, 2006; see Table 4.2).

Table 4.2 Reasons for Underutilization of Mental Health Care Among Racial and Ethnic Minorities in the United States

Some of the key reasons for underutilization of mental health care relate to limits on access to services whereas others relate to cultural norms and misunderstandings that can derail the interview process (Iskandarsyah et al., 2013).

Limits on access	When race and ethnicity intersect with poverty, it can leave clients uninsured or underinsured Lack of awareness of available services Lack of transportation to mental health facilities Language differences between clients and interviewers
Impact of beliefs and	Cultural norms stigmatize disclosure of problems and emotions to strangers, or dictate that they be discussed

attitudes	only with spiritual leaders, medical personnel, or trusted family members Clients fear that failure to understand procedures, remedies, or red tape will make them feel ashamed or appear stupid in the eyes of mental health professionals Previous discrimination against or oppression of clients' ethnic group creates fear and mistrust about being mistreated or improperly labeled by mental health professionals

Thinking Scientifically Is Psychological Diagnosis Biased?

The final item in Table 4.2 is of special interest because of concern that there is bias against racial and ethnic minority groups in the mental health system. Is this perception accurate? As described in Chapter 3, human diagnosticians—like the rest of us—cannot help but have personal biases. They hold expectations and make assumptions tied to gender, age, culture, race, and ethnicity. These cognitive biases could color their judgments and might lead them to apply diagnostic criteria in ways that are slightly but significantly different from one case to the next (e.g., Caetano, 2011; During et al., 2011; Flores, Cobos, & Hagmayer, 2017; Lewis-Fernández et al., 2010).

What am I being asked to believe?

The assertion to be considered is that clinicians in the United States base their diagnoses partly on a client's racial background and other identifying characteristics (but we focus here on race and ethnicity).

What kind of evidence is available to support the claim?

Several facts suggest the possibility of racial bias in psychological diagnosis. For instance, clinicians tend to diagnose schizophrenia spectrum and other psychotic disorders in African American and Hispanic American clients at much higher rates than in European Americans (Aklin & Turner, 2006; Chien & Bell, 2008; Olbert, Nagendra, & Buck, 2018; Schwartz & Blankenship, 2014). Further, certain kinds of odd symptoms tend to be diagnosed as a mood disorder in European Americans, but as schizophrenia in African Americans (Gara et al., 2012; Schwartz & Feisthamel, 2009). And compared to African American children, European American children are more likely to be diagnosed with mood, anxiety, and other less severe disorders (Aklin & Turner, 2006). African Americans are also more likely than European Americans to be discharged from mental hospitals without a definite diagnosis, suggesting that clinicians have more difficulty in diagnosing their disorders (Sohler & Bromet, 2003). Emergency room physicians, too, appear less likely to recognize psychiatric disorders in African American patients than in patients from other groups (Kunen et al., 2005).

There is also evidence that members of racial minority groups are underrepresented in research on psychopathology (Iwamasa, Sorocco, & Koonce, 2002). This lack of minority representation may leave clinicians less aware of sociocultural factors that could influence diagnosis. For example, they might more easily misinterpret an African American’s unwillingness to trust a European American diagnostician as evidence of paranoid symptoms (Whaley, 2001, 2011).

Are there alternative ways to interpret the evidence, including those that my biases and preconceptions might have kept me from seeing?

Differences among racial groups in diagnosis do not automatically indicate bias based on race. Perhaps there are real differences in psychological functioning among different racial groups. If African Americans, for example, are exposed to more risk factors for disorder, including poverty, violence, and other major stressors than other groups are, they could be especially vulnerable to more serious forms of mental disorder (Plant & Sachs-Ericsson, 2004; Russell et al., 2018; Turner & Lloyd, 2004). And there is no guarantee that diagnostic criteria would be significantly different if more African Americans had been included in psychopathology research samples.

What additional evidence would help to evaluate the alternatives?

So, do members of minority groups actually display more signs of mental disorder than other groups do, or do diagnosticians just perceive them as more disordered? One way of approaching this question would be to conduct experiments in which diagnosticians assign labels to clients on the basis of case histories, test scores, and the like. The cases would be selected so that pairs of clients show about the same amount of disorder, but one member of the pair is described as European American and the other as, say, African American. Another option would be to present the same set of case materials, described as representing either African American or European American clients, to different diagnosticians. Bias in

diagnosis would be suggested if, for example, the clinicians saw patients who were described as African American as more seriously disordered than those thought to be European Americans.

Most studies of this type have found little or no racial bias (e.g., Angold et al., 2002; Kales et al., 2005a, b). These results are difficult to interpret, however, because the diagnosticians might have been aware of the purpose of the study and so might have gone out of their way to be unbiased (Abreu, 1999; Gushue, 2004). In fact, researchers have found evidence of some diagnostic bias against African Americans when clinicians were unaware of the purpose of the research (e.g., Baskin, Bluestone, & Nelson, 1981; Jones, 1982; Schwartz et al., 2019). Bias has also appeared in studies aimed at identifying the factors that influence clinicians' judgments following extensive interviews with patients. For example, one hospital study found that in arriving at their diagnoses, psychiatrists were more likely to attribute hallucinations and paranoid thinking to African Americans than to European Americans, whose similar symptoms were more likely diagnosed as depressive disorders (Trierweiler et al., 2000). Another study showed that after being diagnosed with schizophrenia, African Americans were more likely than European Americans to be hospitalized, even when symptoms were about equally severe (Rost et al., 2011).

As already mentioned, some of these differences could reflect racial differences in the rate of disorder in the population. However, when people were interviewed in their own homes as part of large-scale mental health surveys, the diagnosis of schizophrenia was given only slightly more often to African Americans than to European

Americans (Robins & Regier, 1991; Snowden & Cheung, 1990). So the presence of racial bias is suggested, at least for some diagnoses, for patients who are evaluated in mental hospitals but not necessarily for those who are interviewed in their own homes (Trierweiler et al., 2000, 2005).

What conclusions are most reasonable given the kind of evidence available?

The group differences in diagnoses just described certainly appear to reflect biases on the part of clinicians more than differences in the diagnostic criteria themselves (Schwartz et al., 2019), but diagnostic bias does not necessarily reflect deliberate discrimination. Diagnostic bias based on race can operate unconsciously or unintentionally (Abreu, 1999; Boysen, 2009; Flores, Cobos, & Hagmayer, 2017). So no matter how precisely researchers specify the criteria for assigning diagnostic labels, biases and stereotypes are likely to threaten the objectivity of the diagnostic process (Poland & Caplan, 2004; Trierweiler et al., 2000).

Cultural Sensitivity and Cultural Competence. There can be several reasons why clinical interviewers might overdiagnose or underdiagnose psychological disorders among clients from different ethnic groups, but one of them is certainly lack of knowledge. A clinician who is unaware of cultural variations across groups might misinterpret an African American client's reluctance to reveal symptoms as evidence of paranoid ideation rather than as understandable caution or suspicion regarding the mental health system. It can be just as easy for a naïve clinician to mistakenly assume that an Asian

client’s reluctance to disclose personal information is evidence of resistance or lack of insight rather than a cultural prohibition against immediate self-disclosure to strangers. There are also culture-bound syndromes—those that do not fit neatly into *DSM* or *ICD* diagnoses (Correll, Stetka, & Harsinay, 2018). One example is *ataque de nervios*, a syndrome that occurs largely among Hispanic groups and is characterized by anxiety and somatic symptoms. Although it is similar to some DSM or ICD diagnoses, especially panic disorder, it is not identical to them (Moitra et al., 2018; Tolin et al., 2007).

It is important that interviewers and therapists-in-training recognize cultural variations in the expression of distress. Misunderstanding of the meaning of spoken and body language seems to be an especially important problem. For instance, compared with European Americans, Asian clients are more likely to express psychological complaints in terms of somatic symptoms such as nausea, faint vision, and vertigo (Dreher et al., 2017; Hsu & Folstein, 1997). Such culture-specific symptoms may not be attributable to significantly higher rates of somatic symptom and related disorders among Asian people but rather to their cultural belief that it is more acceptable to use somatic terms to convey emotional distress. In short, cultural differences in how symptoms are displayed can easily lead clinicians to misinterpret or misdiagnose them (Li, Jenkins, & Grewal 2012; Ross, Schroeder, & Ness, 2013).

Interviews can also be affected by cultural values such as independence versus interdependence. Among people from Hispanic and Asian cultures, for example, independence may not be as strongly valued as it is among those from Western European cultures (Triandis, 2018). Interdependence and family obligations may be assigned greater value instead. So interviewers

who pursue questioning that seems to imply the value of emotional or psychological independence may unwittingly be alienating clients who sense that the interviewer disapproves of one of their core values.

What should interviewers do when faced with possible cultural issues? It is unrealistic to expect that even experienced clinicians will be familiar with *all* the possible cultural variations they see during interviews, but they can reasonably be expected to possess a thorough understanding of how interview conclusions can be distorted by ethnic and cultural misunderstandings (e.g., Watkins et al., 2019). Interviewers can improve their cultural competency and avoid bias by educating themselves about the more common cultural variations among clients, particularly those related to the ethnic backgrounds of clients they often interview. When confronted with situations that might involve cultural misunderstanding, interviewers should openly explore cultural concerns with the client, thereby conveying a sincere desire to understand, rather than merely to arrive at a diagnosis. They should recognize the limitations of their knowledge and seek consultation from colleagues with more expertise in working with particular kinds of clients. They should also review relevant research literature. Finally, they should be able to recognize cultural differences without falling prey to the dangers of simplistic stereotyping, which can serve to create caricatures related to psychological differences across cultures (Stuart, 2004). The American Psychological Association's (2017e) *Multicultural Guidelines: An Ecological Approach to Context, Identity, and Intersectionality* and other readings (e.g., Sue & Sue, 2007) are designed to guide psychologists' training in, and practice of, culturally responsive services as well as to develop a core understanding of the challenges and opportunities raised by cultural diversity.

Research on multicultural issues in clinical assessment is growing

rapidly. The professional literature now contains studies of such topics as: Is the borderline personality disorder subscale of the Structured Clinical Interview for *DSM-5* Personality disorders valid for Cantonese-speaking Chinese? (Wong & Chow, 2011); what criteria should be used by people who are responsible for assessing the adequacy of trainees' cross-cultural training? (Lanik & Mitchell-Gibbons, 2011); how might psychological service delivery be improved for refugee populations? (Kaczorowski et al., 2011); and is obsessive-compulsive disorder expressed differently among patients in Brazil versus the United States (Medeiros et al., 2017)? Again, practicing clinicians are not expected to have an encyclopedic knowledge of every culture-specific clinical situation, but they are expected to recognize whether their knowledge of multicultural assessment is sufficient to establish competency, and if not, take steps to enhance it (Pérez-Rojas et al., 2019).

In Review Clinical Interview Situations

Types of Clinical Interviews	Purposes
Intake	Establish the nature of client problems; determine suitability of clinician’s services; assess mental status; establish working relationship.
Problem referral	Answer specific diagnostic or other questions for a referral agent or agency.
Orientation	Acquaint clients with upcoming assessment, treatment, or research procedures.
Debriefing and termination	Help clients to better understand completed assessment or research procedures, or to recount traumatic experiences. Bring a program of treatment to an end.
Crisis	Provide emotional support, collect assessment information, and provide help.
Threats to the value of clinical interviews	Ethnic, racial, and cultural differences between interviewer and clients that limit clients’ comfort about disclosing clinically important information.

Test Yourself

1. An interview is a _____________.

2. A researcher is likely to reveal the true purpose of a just-completed research procedure during a(n) __________ interview.

3. Lack of interviewer cultural competence can contribute to the problem of _______ among racial and ethnic minority clients.

You can find the answers in the Answer Key at the end of the book.

Interview Structure

Section Preview The most fundamental feature of clinical interviews is their structure: the degree to which the interviewer determines the content and course of the conversation. At one end of the structure continuum are nondirective, or unstructured interviews, in which the clinician asks open-ended questions and does as little as possible to interfere with the natural flow of the client's speech and choice of topics. At the other end of the spectrum are structured interviews, which involve a carefully planned question-and-answer format. In between are many blends, usually called guided or semistructured interviews. Although structured interviews are increasingly popular, partly because of their greater reliability and validity, they also have some disadvantages.

Several factors influence the degree of structure in an interview; among them are the theoretical orientation and personal preferences of the interviewer. In general, humanistic clinicians tend to establish the least interview structure. Psychodynamically oriented clinicians often provide more structure, while behavioral and cognitive behavioral clinicians are likely to be the most verbally active and directive. Structure may also change during an interview—many interviewers begin in a nondirective way and become more structured as the interview continues. The interview situation also strongly affects the degree of structure. For instance, by their nature, crises demand more structure than might be desirable during a routine intake interview.

Nondirective Interviews

Consider first this segment from a nondirective intake interview.

CLINICIAN: [Your relative] didn't go into much detail about what you wanted to talk about, so I wonder if you'd just start in at whatever you want to start in with, and tell me what kind of nervousness you have.

CLIENT: Well, it's, uh, I think if I were to put it in, in a few words, it seems to be a, a, a complete lack of self-confidence in, and an extreme degree of self-consciousness. Now, I have always been a very self-conscious person. I mean ever, just about, since I was probably 14 years old the first I remember of it. But for a long time I've realized that I was sort of using people as crutches. I mean I, a lot of things I felt I couldn't do myself I did all right if someone was along.

CLINICIAN: Um-hm.

CLIENT: And it's just progressed to the point where I'm actually using the four walls of the house as an escape from reality. I mean I don't, I don't care to go out. I, I certainly can't go out alone. It's sort of a vicious circle. I find out I can't do it, and then I'm sure the next time I can't do it.

CLINICIAN: Um-hm.

CLIENT: And it just gets progressively worse. I think the first that I ever noticed it… . (Wallen, 1956, p. 146)

The client continued a narrative about the onset and duration of her problems, her occupation and marriage, her father's death, and other topics.

Notice that the clinician hardly says a word, although there are things he could have done to nondirectively encourage the client to talk had it been necessary. For example, he could have asked *open-ended questions* such as “Why do you think that happened?” which, unlike *direct questions* that ask for specific information, simply open the door to further elaboration. The nondirective interviewer uses direct questions sparingly and relies instead on responses designed to help clients continue talking about their concerns.

Semistructured Interviews

Compare this nondirective approach to the following semistructured interview, in which an organized set of topics is explored in a way that gives the interviewer flexibility in wording questions, interpreting answers, and guiding decisions about what to address next.

CLINICIAN: You're telling me that you get mad all of a sudden, that anger just seems to explode out of you without warning.

CLIENT: Well yeah, it seems so sudden. It scares me, and I know it scares other people too 'cause I can see how they react.

CLINICIAN: You don't want to frighten other people, have them walk on egg shells, but you know they do.

CLIENT: It's like I'm a child at times. I hate it, hate how it pushes people away.

CLINICIAN: What is your idea of how you should feel in those situations?

CLIENT: I don't know. I should be in control. I guess there's reasons for it, after all the stress and all, but a man should be able to control his temper. I even tell my kids that… I'm such a hypocrite.

CLINICIAN: So you've got a few things going on at once. You get angry easily, it comes on suddenly. After it comes out, you feel ashamed because you think you ought to be able to control it. And then you're concerned about scaring the people you're close to, pushing those people away.

CLIENT: Yeah, I want to be able to relax, take things in stride, but I’m not that person now.

Notice the nondirective features in this excerpt—the clinician’s responses conveyed an understanding of the client’s experience and encouraged further talk but did not dictate what the client talked about by requesting specific information. However, the interviewer also placed limits on the topic by asking a specific question. The more specific questions that interviewers ask, the more structure they impose on the interview.

Semistructured interviews have been developed for a variety of clinical purposes, most of them involving assessment of specific conditions or situations. For example, the *Crisis Intervention Semistructured Interview* was developed to help trained clinicians and novices interview clients in crisis situations. Information from the interview is used to provide a standardized method of arriving at intervention decisions (Kulic, 2005). Another example is the *Clinician Home-based Interview to Assess Function* (CHIF), a semistructured interview used to assess functioning in the elderly who show signs of dementia (Hendrie et al., 2006).

Structured Interviews

In structured interviews, the interviewer asks a series of specific questions phrased in a standardized fashion and presented in an established order. Consistent rules are also provided for coding or scoring the clients' answers or for using additional probes to elicit further scoreable responses. Thus, although structured interviews do not prohibit open-ended questions or prevent interviewers from formulating their own questions to clarify ambiguous responses, they do provide detailed rules (sometimes called *decision trees* or *branching rules*) that tell the interviewer what to do in certain situations (e.g., "if the respondent answers no, skip to question 32; if the respondent answers yes, inquire as to how many times it happened and continue to the next question"). When used to assign psychiatric diagnoses, structured interview protocols also include decision rules called *algorithms* that tell clinicians what specific combinations of symptoms are required for a given diagnosis, such as panic disorder or schizophrenia.

As an example of a fully structured interview, consider the *Diagnostic Interview Schedule for Children* (DISC; Rolon-Arroyo, Arnold, Harvey, & Marshall, 2016). Designed for use by professionals or nonprofessionals in making DSM diagnoses of child and adolescent disorders, the DISC specifies a fixed set of questions and follow-up probes. The interviewer is not allowed to deviate from the prescribed structure. The interview includes questions about whether clients have experienced each of a variety of psychological symptoms, and if so, for how long and how recently. Because this is a fairly broad assessment originally designed for use in research on the prevalence of various disorders, it can take well over an hour to complete. There are many

other structured and semistructured interviews that, like the DISC, are designed to help clinicians arrive at psychiatric diagnoses by asking questions relevant to specific *DSM* diagnostic criteria (see Table 4.3).

Table 4.3 Structured and Semistructured Interviews Frequently Used in Clinical Psychology

Name of Interview	Reference	Purpose
The Schedule for Affective Disorders & Schizophrenia (SADS)	Endicott & Spitzer (1978)	Semistructured interview for differential diagnosis of mood and psychotic mental disorders, among other conditions
Diagnostic Interview Schedule (DIS)	Robins et al. (1998)	Extensive structured interview with several modules used in large-scale epidemiological studies; Chinese and Spanish versions available
Structured Clinical Interview for *DSM-5* Disorders (SCID-5)	First et al. (2015)	Semistructured interview covering broad-scale differential diagnoses tied to *DSM-5* criteria; versions for clinical and for research use
Diagnostic Interview Schedule for	Shaffer et al.(2000)	Parallel formats for children and parents for making differential

Children, Revised (DISC-R)		diagnoses of disorders of childhood and adolescence
Composite International Diagnostic Interview (CIDI-2)	World Health Organization—Alcohol, Drug, and Mental Health Administration (1997)	Many of the same items as the DIS but with modifications to improve cross-cultural use
International Personality Disorder Examination (IPDE)	Loranger (1999)	Differential diagnoses among *DSM-5* personality disorders;
Structured Clinical Interview for Personality Disorders (SCID-5-PD)	First et al. (2015)	Semistructured interview for *DSM-5* personality disorders; combined SCID-5 and SCID-5-PD are designed to provide a comprehensive diagnostic assessment interview
Psychopathy Checklist (PCL-R)	Hare (2003)	Semistructured interview consisting of structured questions and optional probes for evaluating psychopathic personality traits (e.g., dishonesty, lack of guilt)
Rogers Criminal Responsibility	Rogers, Wasyliw, & Cavanaugh (1984)	Assesses criminal responsibility with respect

Assessment Scale (RCRAS)	to specific legal criteria

Advantages and Disadvantages of Structured Interviews. In recent years, structured and semistructured interviews have been used increasingly in a variety of clinical situations (Machado et al., 2011; Segal, Mueller, & Coolidge 2012). This proliferation has occurred even though structured interviews eliminate much of the flexibility of open-ended interviews; they prescribe conversation topics and constrain client answers. So why are structured interviews so popular? The answer comes largely from the fact that they provide a systematic way of assessing the variables that interviews are designed to explore. In other words, though they may not be as flexible, they are less prone to certain sources of error that can affect the reliability and validity of interview assessment data. To understand why, you must understand those sources of error (Shea, 2016; Ward et al., 1962).

One of them, called *client variance*, occurs when a client provides different answers or displays different behaviors in response to the same questions asked by different clinicians. A second source of error, *information variance*, refers to differences in the way clinicians ask questions or make observations. For instance, if two clinicians ask questions in different ways, they might receive different answers. That would certainly be the case if, for example, the questions were phrased as follows: “Do you get anxious whenever you are in crowded places such as malls?” and “What situations seem to make you the most anxious?” Finally, there is *criterion variance*, which refers to disagreements that occur if clinicians apply different standards of judgment to the same set of client responses. For instance,

different clinicians might use different cutoff points or inference rules for deciding what a response means (e.g., what types of responses indicate “significant impairment”). In short, much of the disagreements between clinicians can come not from inconsistencies in client responses but from inconsistencies in the way clinicians collect, interpret, and use those responses (Grove et al., 1981; Ward et al., 1962).

Structured interviews are a mainstay in clinical research because they reduce variance in clinicians’ information gathering, recall, and judgment. The increasing use of structured interviews by clinicians parallels other trends in the history of clinical assessment. As noted in Chapter 3, using formal, statistical rules for combining assessment data is usually equally or more effective than relying on clinicians’ subjective judgments. Structured interviews are designed to make the data collection process more consistent by standardizing how information is gathered. Empirically driven decision rules can also replace, or at least improve, clinicians’ judgments.

At the same time, however, there are limitations to structured interviews. Clinicians who depend too much on structured interviews risk becoming so “protocol bound” that they miss important information that the interview script did not explore. This is another example of the “bandwidth versus fidelity” tradeoff described in Chapter 3. Training in a variety of interview techniques combined with a careful analysis of the goals of the assessment can help clinicians remain open to information that was not obvious at initial referral. For example, at the end of structured interviews clinicians typically ask an open-ended question, such as “Is there anything important that I haven’t asked about or that you haven’t had a chance to tell me?”

The most frequently voiced complaint about structured interviews is that their routinized nature can alienate clients (Segal, Mueller, & Coolidge,

2012). This is especially likely if the clinician does not first establish rapport, fails to fully explain the rationale behind the use of the structured format, or becomes so focused on structured interview assessment that the client feels the interview is more problem-centered than person-centered. So just as in the old medical joke ("the operation was successful but the patient died"), it is possible that in psychological assessment "the diagnosis was impeccable but the client fled treatment" (Segal et al. 2012, p. 97). There is some evidence that this concern may be overstated. In one survey, clinicians tended to perceive structured interviews as off-putting to their clients, yet the clients themselves said that they perceived such interviews as useful, enjoyable, and informative (Bruchmüller et al., 2011).

The fact is that any interview can be administered in a mechanical or stilted manner. To avoid alienating clients in the course of structured interviews, clinicians must remember to enhance rapport by using their interpersonal skills before, during, and after these interviews. For instance, early in an interview, a clinician might preview the structured interview segment by saying something like, "I want to make sure we clarify your major concerns today, so to begin with, I'd like you to tell me what brought you here. Later, if we get into an area that is particularly important or troubling for you, I might ask a series of questions designed to get a more detailed picture of that problem. OK?" When the time comes for the structured or semistructured portion of the interview, the clinician might introduce it by saying something like, "It seems that depression has been a major problem for you lately, so I'd like to ask you some questions to help us better understand the depth of this problem and how we might plan to address it."

A final limitation of structured interviews is that, like all other

interviews, they depend heavily on clients' memory, candor, and descriptive abilities. So although the reliability of clients' reports (or of different clinicians' inferences about those reports) might be excellent, the validity or meaning of structured interview data can be threatened if the client misunderstands questions, is not motivated to answer truthfully, or cannot recall relevant information.

Because both the questions and the inference rules of structured interviews are scripted, they can be conducted by professional clinicians, trained nonprofessionals, or by computer programs (Groth-Marnat, 2003; Peters, Clark, & Carroll, 1998; Pilkonis et al., 1995; Reich et al., 1995). No matter how structured interviews are administered, they are most easily applied to clinical tasks that have well-defined decision-making criteria, such as diagnosis. There are no structured interviews available for most face-to-face clinical work such as therapy interviews. As a result, the unstructured interview remains by far the most common tool used by clinical psychologists on a day-to-day basis (Garb, 2007; Lilienfeld, Miller, & Lynam, 2018). This means that, despite trends toward increasing the structure of many clinical interactions, today's clinicians still need a broad base of skills to manage the various stages of all types of interviews.

In Review Interview Structure

Interview Format	**Main Characteristics**	**Advantages and Disadvantages**
Unstructured; nondirective	Least active interviewer; clients are free to choose how, when, and what to talk about. Commonly used by humanistic clinicians.	+Eases rapport between clinician and client. – Important topics might not be addressed, or not addressed quickly.
Semistructured	Interviewer explores a planned set of topics but in a flexible way that mixes directive and nondirective elements. Commonly used by psychodynamic and cognitive behavioral clinicians, especially in therapy settings.	+Includes benefits of nondirective interviews while assuring coverage of important topics reasonably quickly; especially valuable in crisis situations. –May not be as useful as structured interviews for research purposes.
Structured	Presents a fixed set of questions and probes in a rigid sequence.	+Less prone than other formats to distortion by variation in question-phrasing or response interpretation; ideal for use in clinical research; can be computerized. – Lack of flexibility prevents clinicians from

		exploring potentially important topics; high structure may alienate some clients.

Test Yourself

1. An unstructured format would be least appropriate for use in a ______ interview.

2. Which interview format would be most appropriate for use by interviewers who have no clinical training?

3. Which interview format is associated with the highest fidelity (level of detail) but the lowest bandwidth (breadth of topics)?

You can find the answers in the Answer Key at the end of the book.

Stages in the Interview

Section Preview In this section, we examine techniques commonly employed by clinical psychologists during the beginning, middle, and end stages of interviews. Certain features, such as establishing and maintaining rapport, communicating the goals or purpose of the interview, demonstrating good listening skills, and providing emotional support, are common to most interviews. Others, such as whether to use a structured, semistructured, or unstructured format depend on the goals of the interview. You will see that clinicians and clients must interpret each other's verbal and nonverbal behavior during an interview, so it is important that clinicians are sensitive to various ways in which their communication can be misinterpreted. Sensitivity to differences of interpretation is especially important when clients come from cultural backgrounds that differ from the interviewer's.

Interviews usually begin with efforts at making the client comfortable and ready to speak freely (stage 1), continue into a central information-gathering stage (stage 2), and end with summary statements, client questions, and, if appropriate, plans for additional assessment sessions (stage 3). Stage 2 is generally the longest one, and can have its own substages. Although not all clinical interviews are organized around a beginning–middle–end framework (Craig, 2009), the three-stage model offers a convenient guide for our discussion of typical clinical interviews. There is no single "right" way to conduct an interview, but certain strategies have been found valuable in practice and have thus been adopted by skilled clinicians representing every theoretical approach (Goldfried, 1980; Shea, 2016).

Stage 1: Beginning the Interview

In one sense, the interview begins prior to meeting the client as the clinician processes the information available from the referral source. Sometimes, the clinician has only some general information about a client's complaints, perhaps voiced to an intake coordinator or administrative assistant at the time of a self-referral. In other cases, medical, school, court, or other mental health records may be available. This information can help the clinician to decide whether specific interviewing formats or testing materials might be needed.

The Interview Setting. Certain settings are especially conducive to building rapport. Interviews are typically conducted in a comfortable, private office or, as described in Chapter 10, in clients' homes or in other familiar but private community locations. These alternative locations are particularly appropriate for clients whose cultural background might make standard office surroundings threatening. Regardless of location, creating a sense of privacy helps clients to recognize the interview's confidential nature.

Several other office characteristics can aid rapport. A reassuring equality is established when two people sit a few feet apart on similar chairs of equal height. If the clinician sits in a massive, high-backed chair behind a huge desk placed 6 feet from the client's smaller, lower seat, rapport may be impaired. A desk cleared of other work, along with precautions to hold phone calls and prevent other intrusions, makes it clear that the clinician is fully attentive and sincerely interested in what the client has to say. Personal effects, such as pictures of family and favored vacation spots, can add personal warmth, but posters or other decorations that make bold statements about the interviewer's social or political views might alienate some clients.

It is the client's self-expression, not the interviewer's, that should take priority. From the beginning, the clinician should try to create a warm, comfortable environment that encourages the client to speak freely and honestly about whatever topics are relevant to the interview.

The Opening. Clinicians must handle those first few minutes of initial interviews with great care. This early stage is important because clients may not be ready to talk candidly about personal matters, preferring to take a wait-and-see approach in which they closely control what they say and don't say. If this reserved attitude prevails throughout the interview, the clinician is unlikely to gather very much valuable assessment information.

Accordingly, most clinicians see establishing rapport as their main task during the first part of initial interviews. Rapport can be built in several ways, many of which involve common courtesy. A client's anxiety and uncertainty can be eased by demystifying the interview. Upon greeting, a warm smile, a friendly hello, an introduction (e.g., "I'm Doctor Jenkins"), and a handshake are excellent beginnings to an interview. Small talk about the weather or difficulty in finding the office also eases the client's transition into the interview. Skilled interviewers help their clients to relax by being warm and approachable, but they don't allow informal rapport-building to go on so long that the interview loses its distinctive quality or the client begins to suspect that the interviewer wants to avoid discussion of the topics that prompted the interview. The interviewer should get down to business within the first few minutes, thereby communicating that the client's time and problems are important. This can help build rapport, a process that continues into the second and third stages of the first interview, and into subsequent sessions as well.

Frame-Setting and Transition. Another task that typically

accompanies the opening of an interview is called **frame-setting**. The frame refers to the norms and expectations that surround an interview, consultation, or therapy session (Walter, Bundy, & Dornan, 2005). When clinicians set the frame, they explain to the client the basic ground rules for the interaction. For example, after introductions and a brief period of small talk, the clinician might say something like the following (items in brackets would be replaced by mention of client's specific symptoms or complaints or with case-specific elaboration):

> *We'll have an hour and a half to work together today. During that time, I hope we can talk about [the problems you've been having], maybe get a better handle on how and when these problems began, and how they are affecting you now. My job is mostly to listen at this point, to try to understand [your situation]. As we continue, I might also ask you a set of questions and write some things down to study later. This information should help us understand and also develop a plan of action for [addressing your problems]. Our conversation is confidential—what we talk about stays in this room. The exceptions to this are [here the interviewer might elaborate on limits of confidentiality such as if the client is an imminent threat for self-harm or of harm to others, what information will go to third parties such as insurance companies or referral sources, etc.]. Please feel free to ask any questions you like; I'll do my best to answer them. If we don't complete all that we hope to today—that happens sometimes—we can continue during our next appointment.*

Frame-setting

Establishing the norms and expectations associated with an interview, consultation, or therapy session.

Notice that setting the frame clarifies time boundaries for the interview session, expresses an expectation about what will be covered and what basic roles the participants will take, and briefly introduces the idea of a structure. It also provides assurances of confidentiality as well as its limits and conveys information about the interviewer's commitment. Notice also the interviewer's use of "we," which is designed to enlist the interviewee as an ally in exploring the problem. This introduction of the frame could occur before or after discussion of the client's troubles has begun in earnest, but it should occur relatively early in the interview. Not all aspects of the frame need be introduced at once. Some topics might be discussed more fully later in the interview or during subsequent meetings as framework issues reemerge, as they frequently do in therapy (especially with clients diagnosed with certain disorders, such as borderline personality disorder).

In most cases, frame-setting leads to a *transition* into the second stage of the interview using nondirective, open-ended questions. Common examples are "So what brings you here today?" or "Would you like to tell me something about the problems you referred to on the phone?" A major advantage of these open-ended questions is that they allow clients to begin in their own way. An open-ended invitation to talk allows the client to ease into painful or embarrassing topics without feeling coerced and lets clients know that the clinician is ready to listen (Shea, 2016). Clients often begin with a "ticket of admission" problem that may not actually be the one of greatest

concern to them. The real reason for the visit may appear only after they have "tested the waters" through varying amounts of discussion of less crucial information.

Stage 2: The Middle of the Interview

Transition to the middle of an interview should be as smooth as possible. During frame-setting and transition to the middle of the interview, the clinician will have signaled whether the clinician or the client will be the main director of the interview topics. These signals continue as the interview progresses. At one extreme are open-ended or nondirective techniques, which allow the client great freedom to direct the conversation. At the other extreme are close-ended or directive techniques, which signal that it will be the therapist who largely directs the conversation. As our previous discussion implies, directive techniques are used extensively in structured interviews. Accordingly, the following information refers mainly to clinical interviews that do not use structured instruments. Here are some ways in which the interviewer provides signals about who will lead the conversation.

Nondirective Techniques. Open-ended questions and encouraging remarks are used whenever the clinician wishes to prompt clients to speak while exerting as little influence as possible over what they say. Classic examples of nondirective strategies include questions such as “How did that make you feel?” and remarks such as “Tell me a little more about that.” These strategies are supplemented by tactics designed to help clients express themselves fully and to enhance rapport. The most general of these tactics is called *active listening*, which involves responding to the client’s words in ways that indicate understanding and acceptance and encourage further elaboration. Active listening was represented in the clinician’s “um-hms” in the nondirective interview excerpt presented earlier. Other signs of active listening include comments such as “I see,” “I’m with you,” “Right,” or even

just a nodding of the head or providing other “empathic noise,” such as a friendly grunt (Havens, 1978).

In a related nondirective strategy called *paraphrasing*, clinicians restate what their clients say to show that they are listening closely and to give clients a chance to correct the remark if it was misinterpreted. Humanistic psychotherapist Carl Rogers (1951) called this strategy *reflection* and emphasized the importance of not only restating content but also highlighting client feelings. Consider these examples.

Example A

CLIENT: Sometimes, I could just kill my husband.

CLINICIAN: You would just like to get rid of him altogether.

Example B

CLIENT: Sometimes, I could just kill my husband.

CLINICIAN: He really upsets you sometimes.

Both are reflective responses, but notice that in example A, the clinician merely reworded the client’s remark, and in example B, the clinician reflected the feeling contained in the remark. Most clients respond to paraphrasing by continuing to talk, usually along the same lines as before, often in greater detail. Paraphrasing often is preferable to direct questioning because such questioning tends to change or restrict the conversation, as illustrated in the following interaction.

CLIENT: What it comes down to is that life just doesn’t seem worth living sometimes.

CLINICIAN: How often do you feel that way?

CLIENT: Oh, off and on.

There is a place for questions like this one, but unless the clinician knows enough about the general scope of a problem to start pinpointing specifics, interrupting with such direct questions is likely to limit, and even distort, the assessment picture. Clients who are hit with direct queries early in a nondirective interview may conclude that they should wait for the next question rather than spontaneously tell their story. For many clients, this experience can be frustrating and damaging to rapport. In effect, such behavior invokes the common *doctor–patient interview schema:* The doctor (psychologist) asks questions and the patient (interviewee) answers and then passively waits for the next question. Although this format is appropriate in some situations, such as structured interviews, it is not as effective in drawing clients out and encouraging them to be active participants/explorers in solving their own problems.

Paraphrasing can also be helpful when the clinician is confused about what a client has said. Consider the following:

CLIENT: I told my husband that I didn't want to live with him anymore, so he said "fine" and left. Well, when I got back, I found out that the son of a bitch kept all our furniture!

Most clinicians would have a hard time deciphering the sequence of events described here, but if they simply look confused and say "What?" the client might be put off or assume that the clinician is not particularly smart. Instead, a combination of paraphrase and request for clarification serves nicely:

CLINICIAN: Okay, let's see if I've got this straight. You told your husband you didn't want to live with him, so he left. You later

came back to your house from somewhere else and found he had taken the furniture. Is that right?

Ideally, the client will either confirm this interpretation or fill in the missing pieces. If not, the clinician may wish to use more direct questioning.

Particularly effective for clarifying ambiguous client statements is to focus on *behavioral incidents*, in which interviewers try to elicit specific client actions (Pascal & Jenkins, 1961; Shea, 2007). For example, if a male client says, “I was really aggressive with my wife” last night, the term “aggressive” could mean many things, ranging from making angry remarks to threatening his wife with a weapon. In such a case, the clinician would ask about specific behaviors, though still in an open-ended way: “Help me understand; what exactly did you do last night?” or “Can you give me some examples of what you mean when you say you were aggressive?” As the famed American psychiatrist Harry Stack Sullivan (1954) wisely warned, clinicians can be badly misled when they assume, but fail to confirm, that they understand what clients mean by terms, such as “aggressive,” “depressed,” or “panicky.” The skillful use of behavioral incidents to obtain specific examples of such terms is an essential interviewing skill.

Directive Techniques. Most interviewers supplement nondirective tactics with more directive questions whose form, wording, and content are the result of careful (though often on-the-spot) planning. Consider the following illustrative questions:

A. Do you feel better or worse when your husband is out of town?

B. How do you feel when your husband is out of town?

Example A offers a clear, but possibly irrelevant, two-choice situation. This is a version of the "Do you walk to work or carry your lunch?" question for which the most valid answer may be "Neither." Some clients are not assertive enough in an interview to ignore the choice, so they settle for one unsatisfactory response or the other. Unless there is a special reason for offering clients only a few response alternatives, skilled interviewers ask direct questions in a form that gets at specific information but also leaves clients free to choose their own words.

Along the same lines, experienced clinicians also avoid asking "suggestive questions," that is, questions that suggest their own answers. Notice the implications contained in this query: "You've suffered with this problem a long time?" Such questions communicate what the interviewer expects to hear, and some clients will oblige by biasing their response. Asking "how long have you had this problem?" would be a better alternative. Well-trained clinicians also avoid phrasing questions in the negative, as these can subtly communicate the message that the behavior being asked about is unacceptable (Lilienfeld, 2016). Consider the question, "You haven't thought of leaving your wife, have you?" Clients who are indeed on the verge of abandoning a spouse or romantic partner but are reluctant to disclose it might feel obliged to say no to this question, because the clinician has implied that saying yes would be undesirable. A much better question might be "Have you been thinking about leaving your wife?", or "What are your feelings about staying in your marriage or leaving it?"

Nonverbal Communication. As in all human communication, a constant stream of nonverbal behavior accompanies clients' and interviewers' verbal behavior. Indeed, the nonverbal communication channel usually remains open even when the verbal channel shuts down (see Table 4.4).

Table 4.4 Channels of Nonverbal Communication

Here are some aspects of clients' nonverbal communication that tend to be of greatest interest to clinicians during interviews.

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1. Physical appearance—height, weight, grooming, style and condition of clothing, unusual characteristics, muscular development, hairstyle

2. Movements—gestures; repetitive arm, hand, head, leg, or foot motions; tics or other apparently involuntary movements; pacing; handling of glasses, pens, or other objects

3. Posture—slouching, rigidity, crossing and uncrossing arms or legs, head in hands

4. Eye contact—constant, fleeting, none

5. Facial expressions—smiles, frowns, grimaces, raised eyebrows

6. Emotional arousal—tears, wet eyes, sweating, dry lips, frequent swallowing, blushing or paling, voice or hand tremor, rapid respiration, frequent shifts in body position, startle reactions, inappropriate laughter

7. Speech variables—tone of voice, speed, slurring, lisp, stuttering, blocking, accent, clarity, style, sudden shifts or omissions

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In addition to noting nonverbal client behaviors, clinicians look for inconsistencies between information transmitted through the verbal and nonverbal channels. The statement "I feel pretty good today" will be viewed differently if the client is on the verge of tears than if smiling happily.

Since both members of an interview dyad are sending and receiving nonverbal messages, clinicians must be sensitive not only to incoming signals

but also to those they transmit**.** For example, they try to coordinate their own verbal and nonverbal behavior to convey unambiguous messages to their clients. A client who is struggling to express complex feelings will perceive the words “take your time” as more genuine if the clinician says them slowly and quietly than if they are said mechanically and accompanied by a glance at the clock. Similarly, friendly eye contact, some head nodding, an occasional smile, and an attentive posture let the client know that the interviewer is listening closely. Overdoing it may backfire, however. A plastered-on smile, a continuously knitted brow, sidelong glances, and other theatrics are more likely to convey interviewer anxiety or inexperience than concern.

Clinicians differ as to what they think their clients’ nonverbal behavior means. For example, to a behaviorist, the appearance of increased respiration, perspiration, and fidgeting while a client talks about sex would probably suggest that this topic is associated with emotional arousal. Psychodynamic interviewers may infer more, postulating perhaps that nonverbal behaviors (e.g., twirling a ring on a finger) are symbolic representations of sexual activity. Gestalt therapists might suspect that the client is avoiding awareness of unpleasant feelings associated with the belief that he or she is just “going round in circles.” Whatever they might infer from it, most clinicians believe that nonverbal behavior serves as a powerful communication channel and a valuable source of interview data. In addition to attending to all the aspects of interviewing that we have covered so far in this chapter, clinicians face many other interview-related challenges. Dealing with silences, how to address the client, handling personal questions from clients, note taking and recording, and confronting a client’s inconsistencies are just a few of these. If you are interested in a more detailed exploration of interviewing issues and techniques, consult the sources cited earlier in this chapter.

Combining Interview Tactics. Because interviews can be flexible, clinicians are usually free to combine the various tactics we have described. They may facilitate the flow of a client's words with open-ended requests, paraphrasing, prompts, and other active listening techniques, and then use more directive questions to "zoom in" on topics of special importance. However, directive procedures do not take over completely as interviews progress. They continue to be mixed with less directive tactics. An example of this blending is provided by the concept of *repeated scanning and focusing* in which interviewers first scan a topic nondirectively, then focus on it in a more directive fashion:

CLINICIAN: You mentioned that you tend to avoid crowds. Can you tell me more about that?

CLIENT: Well, I don't like to be in crowds, like at Christmas in a mall or something. And I tend to avoid parties, even though I sometimes make myself go.

CLINICIAN: So being around a lot of people makes you uncomfortable?

CLIENT: Yeah, I sometimes get this worried, panicky feeling, and I'm afraid that I'll say something stupid, make a fool of myself.

CLINICIAN: So can you describe that worry for me, what happens in your body, what you think about, what you do?

CLIENT: It just comes over me, I get nervous and think that I should get out of that situation. If I'm in a crowd, I'll just leave, maybe go to my car and sit by myself for a while. If I'm at a party, I'll find a bathroom or something and hide out for a while, maybe slip out and go for a walk. I don't know how other people do it; I just don't know how else to act.

CLINICIAN: How would you compare social situations when you are required to interact with people to those when you are with people but don't have to interact with them, like in a crowd?

The interviewer might go on to explore several specific aspects of the client's anxiety in social situations, then move on to another topic, again beginning with scanning procedures and later moving on to more direct questions. Clinicians can accomplish a lot by periodically summarizing their impressions. Consider the following example:

CLINICIAN: I wonder if you could say a little more about what your binge eating episodes are like.

CLIENT: You mean, like what I'm thinking about, what I feel?

CLINICIAN: That's right.

CLIENT: Well, it's like a movie, only I'm in it and I have to play this part. Unfortunately, the part I play is this pathetic, ugly person who keeps shoving food in her face. I know that people will think I'm fat, but I can't stop myself.

CLINICIAN: Does this feeling last after the binge episode as well?

CLIENT: Well, yeah. It goes on for a long time after, even if I take laxatives or something. Like a day after the last one, I went out with my roommate and this guy seemed to be interested in me, but all I can think is that he can't possibly be.

CLINICIAN: And so while you are binge eating, it's almost like there is a part of you outside yourself, watching it all happen, but helpless to stop it. And afterward, you feel ashamed, you hate yourself, and you're even

more convinced that you are ugly. And if a man seems to find you attractive, it puzzles you more than anything because you see yourself as so unattractive.

CLIENT: Yes, that's just how I feel.

Stage 3: Closing the Interview

The last stage of an interview can provide valuable assessment data as well as an opportunity to enhance rapport. The interviewer might initiate the third stage with a statement like this:

> *We have been covering some very valuable information here, and I appreciate your willingness to tell me about it. I know our session hasn't been easy for you. Since we're running out of time for today, I thought we could look back over what we've covered and then I'd like to give you a chance to ask* me *some questions, or to let me know if there's anything you think I may have missed or misunderstood.*

The clinician accomplishes several things here. First, the impending conclusion of the interview is signaled. Second, the client is praised for cooperativeness and reassured that the clinician recognized how stressful the interview was (emotional support). Third, the suggested plan for the final minutes invites the client to ask questions or make comments that may be important but had not yet been expressed.

Sometimes, signaling the last stage of an interview evokes behavior or information that is clinically significant. For example, a client might say, "Oh gosh, look at the time. I have to hurry to my lawyer's office or I won't be able to find out until Monday whether I get custody of my son." Some clients wait until the end of the interview to reveal this kind of information because they want the clinician to know about it, but they aren't ready to discuss it in detail. Others might just let the information slip out because the interview "feels" over and they feel less guarded. Some simply don't want the

interview to end. For these reasons, the clinician attaches at least as much importance to the final stage of the interview as to those that precede it. However, because the clinician is responsible for monitoring the boundaries —in this case, time constraints—a comment such as the following might be in order:

> *You must be on pins and needles waiting to find out. That seems so important—custody of your son. We didn't talk about that today, but maybe next time we can. I hope things turn out well for you.*

Through such a response, the therapist expresses empathy, points out in a nonpunitive way that the client omitted this information from discussion, and invites further discussion later.

In Review Stages in the Interview

Stage	Purpose and Characteristics
Beginning	Begin to establish rapport; make client feel comfortable. Establish norms and expectations for the interview (frame setting). Stage 1 ends with transition to Stage 2 using open-ended questions.
Middle	Information gathering using some combination of directive and nondirective interviewing techniques. Nondirective techniques feature active listening (reflection and paraphrasing). Directive techniques pose specific questions. Techniques are combined in scanning and focusing procedures. Attention to clients' nonverbal behaviors, and control over interviewer's nonverbal behaviors.
End	Bringing interview to a close by signaling its end, reinforcing client's cooperation, and discussing plan for further contacts.

Test Yourself

1. The interviewer's primary goal at the beginning of an interview is to____________ .

2. "How old were you when you first noticed that you have a problem with alcohol?" is an example of a ____________ question.

3. Seeing tears in a client's eyes, an interviewer says "That day must have been very difficult for you." The interviewer is paying attention to the

client's_________ behavior and using a nondirective technique called _________.

You can find the answers in the Answer Key at the end of the book.

Evaluating the Quality of Interviews

Section Preview As the primary assessment tool of clinicians, interviews are rich sources of data. They are also complex social interactions that can be interpreted in a variety of ways. Therefore, clinicians need to be aware of potential sources of interview error, including their own biases. Overall, the reliability and validity of unstructured interviews is lower than the reliability and validity of more structured interviews, but proper training and sensitivity to sources of error can maximize the value of all interviews.

The fundamental objective in interview communication—as in all human communication—is to encode, transmit, and decode messages accurately. Speakers must encode what they want to convey into transmittable messages made up of words and gestures, which listeners must receive and decode (interpret) within their personal and cultural frame of reference. Lapses in both verbal and nonverbal communication can occur at many points in this process. To take just the simplest of examples, giving the “thumbs up” sign signals approval to people in the United States, but it says “up yours” in some Middle Eastern countries.

Communication and Miscommunication in the Interview

Clinicians attempt to avoid the much more subtle communication problems that can plague interviews by maximizing the clarity of the messages they send to their clients and by clarifying the meaning of the messages received from them. Skilled interviewers do so by following certain guidelines. For example, they avoid jargon and euphemisms, and ask questions in a straightforward way ("What experiences have you had with masturbation?" rather than "Do you ever touch yourself?"), and request frequent feedback from their client ("Did I understand you correctly that … ?"). They also try to ensure that their verbal behavior conveys patience, concern, and acceptance. Expressing impatience or being judgmental is rarely desirable.

Especially worrisome is the possibility that personal biases might affect interviewers' perceptions and color the inferences and conclusions they draw about what clients say. The role of such biases was noted nearly 70 years ago in a study showing that social workers' judgments of why "skid-row bums" had become poor were related to the interviewers' personal agendas, not just to what respondents said (Rice, 1929). Thus, an anti-alcohol interviewer saw drinking as the cause of poverty, while a socialist interviewer concluded that interviewees' plights stemmed from capitalist-generated economic conditions. Similarly, as discussed in Chapter 2, psychoanalysts and behavior therapists tend to draw different causal conclusions about the behavior problems clients describe during interviews. Indeed, interview-based psychodiagnoses, job interview decisions, and the outcome of medical school admissions interviews may all be prejudiced by information that interviewers

receive about interviewees beforehand (Dipboye, Stramler, & Fontenelle, 1984; Shaw, et al., 1995; Temerlin, 1968).

Other studies conducted in mental health, employment, and other settings have shown that interviewers' judgments can also be affected by clients' ethnicity, the clinician's theoretical orientation, or even the clinician's age (Garb, 1998; Li, Jenkins, & Grewal 2012; Pottick et al., 2007). And as noted in Chapter 3, clinicians are like all other human beings in their vulnerability to confirmation bias, the tendency to seek and recall information that confirms their preexisting biases (Nickerson, 1998). Fortunately, the impact of these factors can be reduced to some extent through training programs that sensitize interviewers to the potential effects of personal biases in interviews.

Reliability and Validity of Interview Data

In the context of interviews, reliability refers to the degree to which clients give the same information on different occasions or to different interviewers, or the degree to which different interviewers draw similar conclusions from what clients say. The validity of interview data relates to the degree to which those data or the conclusions drawn from them, are accurate. The impact of these factors is of special interest to researchers trying to establish the value of interviews for clinical assessment.

Reliability. Researchers study the reliability of interviews in part by examining the consistency of clients' responses across repeated interview occasions. This procedure measures *test–retest reliability*. They also examine the degree to which different judges agree on the inferences (ratings, diagnoses, or personality trait descriptions) they draw from interviews with the same client, a procedure that measures *interrater reliability*.

One particularly useful research strategy to assess interrater reliability is to ask several clinicians to view interview videos and then make ratings or draw other inferences from them. This approach has been widely used to establish the reliability of clinicians' judgments about *DSM* diagnoses (e.g., Axelsson et al., 2016; Widiger et al., 1991), therapists' evaluations of clients' progress in therapy (Goins, Strauss, & Martin, 1995), therapists' ratings of the quality of client–therapist alliances following intake interviews (Shechtman & Tsegahun, 2004), and in a variety of other situations. A general statement about the reliability of interviews is unwarranted because interviews vary so much in their formats and purposes (Craig, 2009). However, as you might expect, test–retest reliability tends to be highest when

the interval between interviews is short and when adult clients are asked for innocuous information such as age and other demographic data (e.g., Ross et al., 1995). Lower reliability coefficients tend to emerge when test–retest intervals are longer, when clients are young children, and when interviewers explore sensitive topics such as illegal drug use, sexual practices, or traumatic experiences (Schwab-Stone, Fallon, & Briggs, 1994; Weiss et al., 1995; Whitehouse, Orne, & Dinges, 2010).

Of course, it is sensitive rather than innocuous information that is usually of greatest interest to clinicians. For this reason, structured interviews are often preferred for eliciting reliable data about sensitive topics. Overall, the test–retest reliability of commonly used structured interviews tends to be satisfactory to excellent, even when the most sensitive information is being requested. For example, test–retest reliability of the DISC is satisfactory (Flisher, Sorsdahl, & Lund, 2012), and the interrater reliabilities of the scales in the Structured Clinical Interview for *DSM-5* are adequate. However, reliabilities tend to be lower when diagnoses are based on interviews conducted by different clinicians than when different clinicians all view the same interview video (Chmielewski et al., 2015).

Reliability also depends on the population on which a structured interview instrument was standardized (Haynes, Smith, & Hunsley, 2018). In other words, an interview method that displays acceptable reliability with one group (e.g., English-speaking European Americans) might not have acceptable reliability with another group (e.g., Spanish-speaking Hispanic Americans). Fortunately, researchers frequently study and measure the degree to which specific instruments apply to diverse groups. As a result, practicing clinicians can have some confidence that, for example, the DISC can be used reliably with South African children (Flisher, Sorsdahl, & Lund 2012) or that

a Spanish-language version of the *Eating Disorder Examination Interview* has reliability comparable to the version developed for English speakers (Grilo, Lorzano, & Elder, 2005). Clinicians should always seek out information about cross-cultural reliability when considering using interview formats (or psychological tests) with clients from different cultural backgrounds.

Validity. The most obvious threats to interview validity appear when clients misremember or purposely distort information. The probability of error or distortion increases when clients are intellectually disabled (e.g., Heal & Sigelman, 1995), suffer from various brain disorders (e.g., West, Bondy, & Hutchinson, 1991), or would prefer not to reveal the truth about their behavior problems, drug use, sexual behavior, criminal activity, or previous hospitalizations (e.g., Morrison et al., 1995). At the other extreme, clients motivated to appear mentally disturbed may give inaccurate interview responses aimed at suggesting the existence of a mental disorder (Rogers & Bender, 2018). Concern about such *malingering* led to the creation of special interview methods aimed at detecting it (Rogers et al., 1991). In short, the desire to present oneself in a particular light to a mental health professional —called *impression management* (Braginsky, Braginsky, & Ring, 1969) —can undermine the validity of interview data.

As described in Chapter 3, validity can be established in several ways, such as by including all of the relevant aspects of a target domain (content validity), by comparing interview results with other valid measures of the same concept (concurrent validity), or by evaluating an interview's ability to forecast expected future outcomes (predictive validity). The latter two involve selecting an external criterion as the standard against which interview conclusions are measured. That external criterion is sometimes called the

gold standard (Komiti et al., 2001), although this term is arguably misleading given that virtually all psychological measures are imperfect (Faraone & Tsuang, 1994).

When structured diagnostic interview outlines are being developed, they are typically validated against this "gold standard" of clinical judgment (e.g., Zetin & Glenn, 1999). Sometimes, however, it works the other way around: clinical judgments are validated against the "gold standard" provided by established structured interviews (e.g., Komiti et al., 2001). How can we evaluate interviews if they are sometimes validated against clinical judgment and sometimes used as a standard for evaluating clinical judgment?

Data on predictive validity can help. Greater confidence in the value of any assessment tool is warranted when it can reliably predict certain outcomes. Thus, an interview designed to assess clients' responses to therapy can demonstrate predictive validity when it clearly distinguishes those who later drop out of therapy from those who do not. Validity is also enhanced when instruments correlate with several conceptually similar indices (*convergent validity*) or are largely or entirely uncorrelated with measures of conceptually different phenomena (*discriminant validity*). For example, scores on a structured interview for hypochondriasis should not correlate highly with scores on measures of quite different conditions, such as narcissistic personality disorder.

In general, the validities of unstructured interviews tend to be lower than those of structured interviews, probably because different interviewers ask different questions and interpret answers differently (Dawes, 1994; Wiesner & Cronshaw, 1988). This finding is rather disconcerting, especially because unstructured interviews are routinely used as selection devices to help determine candidates' suitability for jobs, admission into graduate or

professional schools, and the like. Available evidence suggests that employers should probably place less weight on unstructured interviews than they do. In fact, some results show that using data from unstructured interviews to supplement the results of well-validated psychological tests such as the MMPI-2 (see Chapter 5) can actually reduce the validity of overall clinical judgments and predictions (Dana, Dawes, & Peterson, 2013; Kausel, Culbertson, & Madrid, 2016.). That's probably because, in making those judgments and predictions, clinicians tend to place too much weight on unstructured interview data that, though vivid and memorable, may not be as valid as the test data. In short, clinicians may sometimes be wrong when they assume that unstructured interviews can only help the assessment process.

Still, there are many kinds of interviews, so as in the case of reliability, no blanket statement about interview validity is warranted. As one distinguished researcher put it, "The interview has been used in so many different ways for various purposes, by individuals with varying skills, that it is a difficult matter to make a final judgment concerning its values" (Garfield, 1974, p. 90). However, in general, the interview formats that have the highest validity are those that are more structured and have been cross-validated using multiple indices (see Table 4.3). In addition, concurrent validity tends to be higher for interviews in which there is evidence of good rapport and clients feel they are being listened to (Nakash & Alegría, 2013).

In Review Evaluating the Quality of Interviews

General threats to value of interview data	Poorly phrased questions. Lack of rapport with client. Biased interpretation of clients' responses. Clients' inability to remember information or motivation to distort information.
Reliability (test–retest and interrater)	No general conclusion warranted, but test–retest reliability generally higher when clients are adults, interval between interviews is short, and innocuous information is requested. Structured interviews tend to be more reliable than unstructured ones, especially when properly standardized for various populations. Interrater reliability tends to be higher when clinicians all see the same interview.
Validity (content, concurrent, convergent, discriminative, predictive)	No general conclusion warranted, but the validity of structured interviews tends to be higher than unstructured ones.

Test Yourself

1. Interviewers whose conclusions about a particular client are affected by what they expect from such a client illustrate the impact of _____________.

2. The generally higher validity of structured interviews is largely based on the fact that they pose _________ questions to every client.

3. In some cases, adding data from unstructured interviews can _______ the validity of clinical judgments based on standardized psychological tests.

You can find the answers in the Answer Key at the end of the book.

Observational Assessment

Section Preview Observations occur during interviews, so some of what we want you to know about observation has already been covered. Still, there are certain more formal observational assessment techniques that differ from interviews. Clinicians can observe client behaviors as they occur naturally in hospitals, schools, homes, and other settings. They can also assess clients by developing contrived situations designed to elicit or assess particular kinds of responses. These techniques can often provide information not otherwise available, especially information about situational determinants of behavior and its ecological validity.

Observational methods have been defined as “the selection, provocation, recording, and encoding of behaviors” (Weick, 1968). This definition highlights the fundamental elements of nearly every type of observational system. The observer first *selects* people, classes of behavior, events, situations, or time periods to be the focus of attention. Second, a decision is made about whether to *provoke* (i.e., artificially bring about) behaviors and situations of interest or to wait for them to happen on their own. For example, to observe how a socially anxious person responds under stress, a clinician could either wait for a stressful event to occur (and hope to be able to observe it) or create one by asking the person to, say, give a speech. Third, plans are made to *record* observations using observer memory, record sheets, audio or video recording, physiological monitoring systems, timers, counters, or other means. Finally, a system for *encoding* raw

observations into a more usable form must be developed. Encoding is often the most difficult aspect of any observational procedure.

Observational methods

The selection, provocation, recording, and encoding of behaviors.

Observational assessment systems are used to collect information that is not available in other ways and/or to supplement other data as part of a multiple assessment approach. For example, if an elementary school teacher and pupil differ in their reports about why the pupil is having trouble in class ("He's a brat," "She's mean"), a less biased picture of the relationship will probably emerge from observations by neutral parties of relevant classroom interactions. In other instances, knowing what a person can or will do is so important that only observation can suffice. Thus, a resident at a halfway house for severely mentally ill people may report feeling ready to leave, but that statement in an interview may be less valuable than observing the resident's ability to hold a job, manage finances, use the bus system, and meet other demands of everyday life.

Clinicians who place greater emphasis on overt (observable) behavior have improved on informal observation methods in at least two ways. First, they have developed more accurate and systematic methods for observing and quantifying behavior. Second, they have demonstrated the feasibility of collecting observational data in situations beyond the testing or interview room. Together, these developments have made it possible for clinicians and

researchers to scientifically observe a wide range of human behavior in a multitude of settings (e.g., Costello et al., 2019).

Goals of Observational Assessment

Observational methods of assessment developed in parallel with assessment via interviews. Both methods were recognized early as rich sources of data about clients, but it became clear that the meaning of observations were too often in the eye of the beholder—different observers saw different things, or they interpreted the meaning of the same observation differently. To remedy this problem, observational assessment methods have become more structured, much as happened with interviews. Most observational techniques now define observational targets (i.e., specific behaviors that are to be observed) and specify how those behaviors should be recorded, combined, and interpreted. Many of these *structured observations* were first developed for use in research, but as their reliability, validity, and ease of use has increased, so has their prevalence in clinical practice.

Supplementing Self-Reports. Self-reports gathered from interviews and some kinds of tests may be inaccurate. It can be difficult for most people to provide objective and dispassionate reports on their own behavior, especially in relation to highly charged emotional events. It is questionable, for example, whether a distressed couple can accurately and objectively describe their own behavior in the relationship, especially behavior that occurs during arguments. Other clients, such as those with dementia or severe schizophrenia, are sometimes unable to give accurate self-reports despite their best efforts to do so. Observational data are likely to provide much more valid information in these situations (Larner, 2005; Lints-Martindale et al., 2012; Miltenberger & Weil, 2013).

In some cases, clients purposely distort their self-reports, usually by offering an overly positive portrayal of their behavior. Distortions are particularly common in self-reports by participants in smoking, drug, or alcohol treatment programs, which is the main reason such reports are often supplemented by family members' observations or by biological measures that can detect the presence of target substances. The possibility that clients may intentionally distort responses on personality tests such as the MMPI-2 are so widely recognized that special indicators have been devised to detect when clients are not responding honestly (see Chapter 5). Observational assessment can help correct for these and other self-report inaccuracies.

Highlighting Situational Determinants of Behavior. Much of traditional clinical assessment is guided by the assumption that responses to interviews and tests are adequate for understanding clients' personalities and problems because those responses reflect general traits that control behavior across many situations. For clinicians adopting this view, observations are seen as *signs* (think "signify") of more fundamental, unobservable constructs. In contrast, clinicians who take a behavioral or cognitive behavioral view tend to regard observational data as *samples* of behavior that help them understand important *person–situation interactions*. They are less likely to draw inferences about hypothesized personality characteristics or problems presumed to be stable across situations and over relatively long time periods. For example, rather than thinking of a client as generally angry, the clinician would want to understand what particular situations or interpersonal interactions are most likely to trigger anger. Conducting observation-driven functional analyses allows clinicians to avoid the need to engage in the relatively high levels of inference typically associated with sign-oriented testing and interviewing approaches (Beavers, Iwata, & Lerman, 2013).

Observational procedures are designed to collect “just the facts,” thereby minimizing the likelihood of drawing incorrect inferences about clients. Observational assessments allow the clinician to determine the circumstances under which problematic behaviors are most likely to occur, what situational stimuli tend to trigger those behaviors, and what reinforcing consequences in the situation serve to maintain the unwanted actions (Patterson, 1982). Traditional tests and interviews are not designed to accomplish this kind of functional analysis (Miltenberger & Weil, 2013).

Enhancing Ecological Validity. Because observational assessment can occur in the physical and social environments where clients actually live, it can provide the clearest possible picture of people and their problems. Not only are these observations likely to be *ecologically valid*, meaning that they tend to mirror real-world contexts, they often provide situational details that help clinicians design treatment programs that can be most easily implemented in home, school, or work environments. This custom-tailoring of interventions may increase the chances for treatment success.

Limitations of Observational Assessment

Early forms of clinical observation required observers to make decisions and draw inferences about what certain behaviors mean and which behaviors should or should not be recorded. As a result, the interrater reliability of observation suffered. Lee Cronbach (1960, p. 535) summarized the problem well: “Observers interpret what they see. When they make an interpretation, they tend to overlook facts which do not fit the interpretation, and they may even invent facts needed to complete the event as interpreted.” In other words, they often fall prey to confirmation bias.

To reduce unsystematic reporting of observations, most modern observation schemes focus the observer’s attention on specific behaviors. The frequency and intensity of these behaviors are then recorded on a checklist or rating scale. The more specific the observations to be made, the fewer judgment calls are required by the observer (for example, “strikes another child with the hand” is more specific than “is violent”). The observers are also trained to use these methods consistently so that interrater reliability is as high as possible. As part of training for observation, clinicians or researchers may practice applying the observational assessment form or scale to videos of a particular set of client behaviors, such that there is no variability in what actually happened. This practice, designed to standardize clinicians’ understanding and application of an observational assessment measure, is called *calibrating*.

Even when observational measures can be obtained easily and reliably using structured observation systems, some clinicians resist using them out of concern that focusing on a few specific observational targets might cause

them to miss other client behaviors of interest. These clinicians are less concerned about the potential unreliability of unstructured observations than they are about the possibility of failing to notice clinically significant information while focused on a restricted observational range.

As with interviews, choices about how much structure to use in observations need not be “either–or,” structured versus unstructured. Structured observations can, and typically do, take place within the context of less-structured observations; indeed, interviews, tests, and other forms of assessment all provide opportunities to observe client behaviors. So clinicians may be able to make general inferences about personality or functioning on the basis of a structured observation that was designed to help in diagnosis, treatment planning, cross-validating self-reports or reports from parents, teachers, and so forth.

Of course, collecting observational data can also be a difficult, time-consuming, and expensive process, and these problems are another reason that some clinicians choose not to use formal observational assessment (Mash & Foster, 2001). Fortunately, not all observational approaches require large investments of time and effort, so well-trained clinicians remain mindful of both the strengths and limitations of various forms of observation.

In Review Observational Assessment

Goals of Observation	Examples
Supplement self-report data	Verify accuracy of former drug-user's report of abstinence.
Identify situational determinants of behavior and behavior problems	Discovery of circumstances that trigger a child's aggression on the playground.
Improve ecological validity (obtain data that is typical for the client)	Watch family interactions in the home rather than in an artificial laboratory situation.
General threats to the value of observational assessment	Observer bias. Inconsistent use of observation system across observers.
Methods for maximizing the value of observational assessments	Use of structured observation systems. Careful training of observers.

Test Yourself

1. Observers' reports can be affected by what they expected to see in a client's behavior. This is an example of ____________ at work.

2. Traditional clinical psychologists see observational data as _______ of relatively stable cross-situational client traits, whereas behavioral clinicians see those data as _______ of behavior in particular situations.

3. When multiple observers learn to code behavior consistently by comparing notes after they have all watched the same behavior, the

process is called ____________.

You can find the answers in the Answer Key at the end of the book.

Approaches to Observational Assessment

Section Preview Observational assessments can be seen as falling along a few basic dimensions. We have already mentioned one of these dimensions, namely the degree of structure involved. Another dimension involves the settings in which observations take place: these settings can range from naturalistic to controlled. In naturalistic observations, client behavior is assessed in the settings where it normally occurs, such as homes, schools, hospitals, shopping malls, and the like. In controlled observations, clients are assessed in specially constructed situations designed to elicit behaviors of clinical interest. Examples include mock job interviews or other role-playing scenarios, and computer-generated virtual reality environments. As described in the previous section, all observational assessments require that clinicians select specific target behaviors and use a system to record observations. Ideally, that system will limit the biases and other errors that can impair the accuracy of observations.

In **naturalistic observation**, the clinicians or researchers look at behavior as it occurs in its natural context (e.g., at home or school). **Controlled observation** lies at the other extreme; the clinician or researcher sets up a special situation in which to observe behavior. Between these extremes are approaches that blend elements of both to handle specific assessment needs, thus creating many subtypes of both naturalistic and controlled observation. In some assessment situations, the observers may be *participants*, in the sense that they are visible to the clients being watched and may even interact with them (as when parents record their child's

behavior). *Nonparticipant* observers are not visible, although in most cases ethical considerations make it likely that the clients are aware that observation is taking place. As we have mentioned earlier, a key goal in any type of observation is to reduce observer bias (Haro et al., 2006).

Naturalistic observation

Watching behavior as it occurs in its natural context.

Controlled observation

Watching clients in specially constructed situations designed to elicit behaviors of clinical interest.

Naturalistic Observation

Natural settings, such as home, school, or work, provide a background that is realistic and relevant for understanding a client's behavior and the factors influencing it. In addition, naturalistic observation can be performed in ways that are subtle enough to provide a picture of behavior that is not distorted by the client's self-consciousness or motivation to convey a particular impression. In naturalistic observation, the primary focus is on assessing the nature of, and changes in, problems that clinicians are asked to solve —everything from eating disorders, intrusive thoughts, and maladaptive social interactions, to parenting behaviors, classroom disruptions, and psychotic episodes (Haynes, 1990).

Observation by Participant Observers. The classic case of naturalistic observation is the anthropological field study in which a scientist joins a tribe, subculture, or other social organization to observe its characteristics and the behavior of its members (e.g., Mead, 1928; Williams, 1967). In such cases, the observer is a participant in every sense of the word, and observations are usually recorded in anecdotal notes that later appear as a detailed account called an *ethnography*.

Because some clinical researchers question whether participant observers can do their job without inadvertently influencing the behavior they are to watch, observations are sometimes conducted by people who are part of the client's day-to-day world. In the following sections, we describe naturalistic observation systems that, while not entirely unobtrusive, allow for recording the frequency, intensity, duration, or form of specific categories of

behaviors by those who are both familiar to clients and in a position to observe them in a minimally intrusive way.

Many observational tools are available to measure clinically relevant behaviors in clients' homes (e.g., d'Apice, Latham, & von Stumm, 2019). As was the case in other areas, early home-based clinical observations required a great deal of inference and provided a rather unsystematic selection of target behaviors (e.g., Ackerman, 1958). More reliable home observation systems have now evolved. One of the first of these was designed by Gerald Patterson (Patterson et al., 1969) for use in the homes of conduct-disordered children. A more recent example is the Home Observation for Measurement of the Environment (conveniently abbreviated as HOME), which was designed to assess characteristics of home environments that may affect child development (Glad et al., 2012).

The desire to observe children's behavior for clinical and educational purposes has spawned a number of systems for use in schools, playgrounds, and similar settings (Bunte et al., 2013; Nock & Kurtz, 2005; Ollendick & Greene, 1990). Classroom observation may focus on a single child and those with whom the child interacts, or an observer can sequentially attend to and assess the behavior of several target children or even of a whole class (Milich & Fitzgerald, 1985). You can read more about the observational assessment of children and the instruments designed for this purpose in Chapter 11.

When it comes to hospitalized patients, observation can be an important component of clinical assessment. One observation scale, for example, includes as many as six measures intended to assess the amount of pain experienced by dementia patients, who often have difficulty communicating their level of discomfort (Lints-Martindale et al., 2012). Another measure, rather amusingly called the NOSIE (Nurses Observation Scale for Inpatient

Evaluation), allows nursing staff and other health professionals to code specific behaviors of inpatients, including behaviors that reflect depression, irritability, and psychotic features (Honigfeld, Gillis, & Klett, 1966; McGill et al., 2017).

Hospitals and clinics are also excellent places to observe the developing skills of trainees who are learning to conduct interviews and other assessments. Psychologists-in-training, medical interns, and others who will eventually need to conduct these procedures can be observed by supervising faculty; these observations are a critical component of clinical training. As with other observations, however, supervising faculty must develop clear measures of the specific behaviors that they observe if they are going to provide useful and unbiased feedback to trainees (Holmboe, 2004).

Self-Observation. Clients are often asked to observe their own behavior using a process called *self-monitoring.* The clients record the frequency, location, duration, or intensity of events such as exercise, headaches, pleasant thoughts, hair-pulling, smoking, eating habits, stress levels, sleeping problems, anxiety, healthy behaviors, or the like. Usually the client and therapist agree on the specifics of the target behaviors to be observed, and the client maintains a record or diary of when those behaviors occur, the conditions under which they occurred, and, often, the thoughts associated with each occasion. Numerous brief self-report measures of symptoms and behaviors are now used with clinical populations (see Table 4.5). Most deliver reasonably good quality data, but self-monitoring of targets such as drug use often are prone to underreporting (Clark & Winters, 2002).

Table 4.5 Examples of Self-Report and Observational Measures

Name	Approximate Administration Time	Assessment Targets
Treatment Outcome Package (TOP) (Kraus, Seligman, & Jordan 2005)	5–10 minutes	A variety of treatment domains; brief measure of treatment outcome
Holden Psychological Screening Inventory (HPSI) (Holden, 1991)	5–7 minutes	General measure of psychopathology; measures social as well as psychiatric symptoms
Hospital Anxiety and Depression Scale (HADS) (Zigmond & Snaith, 1983)	5 minutes	Psychological symptoms of anxiety and depression
Laboratory Parenting Assessment Battery (Lab-PAB) (Wilson & Durbin, 2012)	2 hours	Rates a broad range of parenting behaviors
Direct Observation Form (DOF) (McConaughy & Achenbach, 2009)	10 minutes	Conduct problems typically seen in school settings

Unobtrusive and Corroborating Measures. The use of “insiders” as observers of adult behavior for clinical purposes is uncommon but not unheard of. For example, in helping clients quit smoking, a clinician may ask for corroborative reports of success from family members or friends (e.g., Mermelstein, Lichtenstein, & McIntyre, 1983). Such reports may also be

solicited as part of the assessment of alcohol or drug use (e.g., Frank et al., 2005), sexual activity (e.g., Rosen & Kopel, 1977), marital interactions (Johnson, 2002; Jouriles & O'Leary, 1985), and other adult behaviors.

Another approach to naturalistic observation is to inspect the by-products of behavior. For example, school grades, arrest reports, and court records have been used to evaluate the treatment of delinquent youth and adult offenders (Davidson et al., 1987; Rice, 1997); changes in academic grade point averages have served as indices of improvement in test anxiety (Allen, 1971). Life records, also called *institutional* or *product-of-behavior* measures (Haynes, 1990), are part of a broader observational approach, called *nonreactive* or *unobtrusive measurement*, which clinical psychologists and other behavioral scientists use to learn about people's behavior without altering it in the process (Connelly, 2017; Kelly & Agnew, 2012).

Unobtrusive measures may also be used in clinical research to test theories about the causes of behavior problems. A particularly creative use of unobtrusive measures in identifying the precursors of schizophrenia occurred in a study of videos that parents made of their children as they were growing up (Walker et al., 1993). Trained observers analyzed the videos of individuals who later developed schizophrenia as well as of their same-sex siblings who did not. The results revealed that long before they were diagnosed, the patients-to-be showed significantly more negative facial expressions than did the children who did not develop the disorder. Some of the differences appeared before the children were 4 years old.

Controlled Observation

Because naturalistic observation usually takes place in an uncontrolled environment, unanticipated events can interfere with the assessment process. For example, the client may move out of the observer's line of vision or might get help from someone else in dealing with a stressor. How would the client have reacted without help? It is impossible to know. Another limitation of naturalistic observation is the long period of waiting that may be required before low-probability events occur (e.g., a child's tantrum or a family argument).

One way of getting around some of the difficulties associated with naturalistic observation is to set up special circumstances under which clients can be observed as they react to planned, standardized events. This approach is usually called *controlled observation* because it allows clinicians to maintain control over the assessment stimuli in much the same way as they do when giving the psychological tests described in Chapter 5. Controlled observations are also known as *analog behavior observation* (ABO), *situation tests*, and *contrived observations*.

Early examples of controlled observational assessments for clinical purposes occurred during World War II when military psychologists devised them as part of their measurement of soldiers' personality traits and behavioral capabilities. In the Operational Stress Test, for example, would-be pilots were asked to manipulate the controls of an aircraft flight simulator. The candidates did not know that the tester was purposely trying to frustrate them by giving increasingly complicated instructions accompanied by negative feedback (e.g., "You're making too many errors"; Melton, 1947).

During the test, the assessor rated the candidate’s reaction to criticism and stress, and these ratings supplemented objective data on skill with the simulator.

Psychologists working in the Office of Strategic Services (OSS, later to become the CIA) used observational assessment to measure initiative, dominance, cooperation, and group leadership traits among potential espionage agents and other special personnel. In one situation, a candidate was assigned to build a 5-foot cube-shaped frame out of large wooden poles and blocks resembling a giant Tinkertoy set. Two assistants (actually, psychologists) called “Kippy” and “Buster” were assigned to “help” the candidate, but in fact did the opposite. Kippy acted in a passive, sluggish manner. He did nothing at all unless specifically ordered to, but stood around, often getting in the way. Buster, on the other hand, was aggressive, full of impractical suggestions, ready to express dissatisfaction, and quick to criticize what he suspected were the candidate’s weakest points. It was their job to present the candidate with as many obstructions and annoyances as possible in 10 minutes. As it turned out, they succeeded in frustrating the candidates so thoroughly that the construction was never completed in the allotted time (Office of Strategic Services, 1948). Since World War II, other versions of the OSS situational tests have been used for personnel selection in the military as well as in the private sector.

Performance Measures. In clinical and research settings today, controlled observations take many forms. In some cases, the “control” consists of asking clients—usually couples, families, or parent–child pairs—to come to a clinic or laboratory where they are observed while engaging in a discussion or an attempt to solve a problem. For example, during marital therapy, a couple might be asked to discuss an area of conflict between them

as the therapist makes audio or video recordings for later analysis (Heyman, 2001; Schudlich, Papp, & Cummings, 2011). The eating style (amount, speed, preferences) of individuals in a weight-loss program might be recorded during a meal or snack in a controlled setting (Spiegel, Wadden, & Foster, 1991). Alcoholic and nonalcoholic drinkers might be observed in specially constructed cocktail lounges located in hospitals or in real bars (Collins, Parks, & Marlatt, 1985; Larsen et al., 2012).

Role-Playing Tests. Clinical psychologists sometimes create make-believe situations in which clients are asked to act out, or *role-play*, the behavior that is typical of them in such situations. As described in Chapter 8, role-playing has long served as a cornerstone for certain kinds of psychodynamic and humanistic psychotherapy (e.g., Moreno, 1946; Perls, 1969), but it was not until the late 1960s that it became part of systematic clinical assessment. Since then, role-playing tests have become a standard ingredient in the observational assessment of children's social and safety skills (Harbeck, Peterson, & Starr, 1992), parent–child interactions (Carneiro, Corboz-Warney, & Fivaz-Depeursinge, 2006), depressive behavior (Bellack, Hersen, & Himmelhoch, 1983), responses to threatening situations (Jouriles et al., 2010), the social competence and conversational skills of socially anxious or chronically mentally ill people (Norton & Hope, 2001), therapists' competence in delivering treatment (Fairburn & Cooper, 2011), and many other targets.

In most role-plays, the clients' or trainees' responses are recorded and then rated by observers on any of dozens of criteria such as appropriateness of content, level of positive and refusal assertiveness, expressed anxiety, latency to respond, response duration, speech dysfluencies, posture, eye contact, gaze, hand gestures, head movements, and voice volume. For

example, the *Extended Interaction Test* assesses the generality and robustness of clients' assertiveness skills by presenting an audio recording of someone who confronts the client with a series of gradually escalating unreasonable requests and demands (McFall & Lillesand, 1971). The assumption is that a person who withstands repeated requests is more assertive than one who gives in after an initial refusal.

Sometimes, clinicians or researchers use a *staged naturalistic event*. The idea is to observe behavior in a controlled setting that appears naturalistic to the client (Gottman, Markman, & Notarius, 1977). For example, unobtrusive role-playing tests have been used to measure social skills in psychiatric inpatients (Goldsmith & McFall, 1975). In these tests, the client is asked to meet and carry on a conversation with a stranger (actually a clinician's assistant) who has been instructed to confront the client with three "critical moments": not catching the client's name, responding to a lunch invitation with an excuse that left open the possibility of lunch at another time, and saying "Tell me about yourself" at the first convenient pause in the conversation. Similar contrived situations—such as presenting prospective parents with a doll and instructing them to role-play a situation or having parents respond to a video of an incident of child misbehavior—have been used to assess parenting skills (Carneiro, Corboz-Warney, & Fivaz-Depeursinge, 2006; Hawes & Dadds, 2006) and social behaviors (Kern, 1982).

Of course, observations involving deception and possible invasion of privacy must be set up with care and with regard for clients' welfare and dignity. Proponents of unobtrusive controlled observation must try to avoid its potential dangers and point out that its value may be limited to measuring

specific behaviors (such as refusal) rather than more complex interactive social skills.

Physiological Measures. Other performance tests measure physiological activity, such as heart rate, respiration, blood pressure, skin conductance, muscle tension, and brain activity that appears in relation to various stimuli. A classic example was Gordon Paul's (1966) use of measures of heart rate and sweating taken just before giving a talk to help identify speech-anxious clients. These measures were repeated following various anxiety-reduction treatments to aid in the evaluation of their effects (see also Nietzel, Bernstein, & Russell, 1988).

In recent years, clinical psychologists have increased their use of physiological measures because they have become much more involved in studying insomnia, headache, chronic pain, sexual dysfunctions, gastrointestinal disorders, HIV/AIDS, diabetes, opioid abuse, and many other disorders that have clear psychological components (see Chapter 12). For instance, consider physiological measures in the assessment of sexual arousal and sexual dysfunctions. In one such performance assessment system, male subjects listen to audio or watch videos that present various types of erotic behavior involving socially appropriate and inappropriate sexual stimuli. All the while, a strain gauge attached to the participant's penis records changes in its circumference (called *phallometric measurement*). Greater erectile responses to the recorded material are assumed to signal higher levels of sexual arousal. Some studies have shown that among child pornography offenders, those with higher levels of erectile response are also more likely to engage in pedophilia (Seto, Cantor, & Blanchard, 2006). Unfortunately, patterns of arousal to specific kinds of stimuli have not been identified for each of the various kinds of sex offenses (Blanchard & Barbaree, 2005;

Looman & Marshall, 2005), but there is hope that this or other technology, such as measures of pupil dilation (Rieger, 2012), will eventually be able to do so.

The use of physiological recording devices in clinical assessment will likely continue to increase, especially now that many companies are marketing relatively inexpensive, portable devices—including virtual reality systems—that present stimuli and record clients' responses.

Virtual Reality Assessment. In *virtual reality* assessment, a client is exposed to a realistic simulation run by a computer. Sometimes, the client views a computer screen, but often the simulation is presented via a headset, helmet, and gloves that provide visual, auditory, and sometimes tactile stimuli. This technology allows for the precise presentation and control of stimuli that appear three dimensional; the experience is usually highly realistic for clients. During the presentation, clinicians can obtain self-report measures, conduct behavioral observations, and collect physiological measures or other assessment indices. The collection of such measures has helped establish the value of virtual reality both as an assessment tool and in the administration of treatments (Côtè & Bouchard, 2005; Llobera et al., 2013; Powers & Rothbaum, 2019).

Virtual Reality

This client wears a virtual reality display that, under a clinician's control, creates the visual experience of seeing spiders of various sizes at varying distances. Systems like this can be used to assess initial fear responses as well as changes in fear during and following treatment for phobias.

(Source: Thierry Berrod, Mona Lisa Production/Science Photo Library.)

Concerns that assessments based on simulations or virtual reality may not carry over to real situations appear to be largely unfounded. Flight simulation training has long been established as an effective method of assessment and training among civilian and military pilots. Except perhaps for some clients with autistic spectrum disorders, virtual reality assessments and treatment applications appear to transfer to real-world settings quite well (Standen & Brown, 2005). In one study, for example, a driving simulator was used to assess the long-term driving performance of clients who had suffered from traumatic brain injury (Lew et al., 2005). In this case, the virtual reality assessment was better at predicting future performance than was an actual road test. Another study (Jouriles et al., 2010) found that role-playing supplemented by virtual reality stimuli elicited stronger and more differentiated responses than role-playing alone. You can read more about virtual reality in Chapters 6 through 9, where we describe various kinds of psychological treatments.

Behavioral Avoidance Tests

Another type of performance measure used in controlled observation is the behavioral avoidance test, or BAT. It is designed to assess overt anxiety in relation to specific objects and situations. In BATs, clients are confronted with a stimulus they fear while observers record the type and degree of avoidance displayed. Informal BATs were conducted with children as early as the 1920s (e.g., Jones, 1924a, b), but it was not until the early 1960s that systematic avoidance testing procedures became a common form of controlled observational assessment.

One of the earliest of these assessments was used in a study of treatments for snake phobia (Lang & Lazovik, 1963). Clients were asked to enter a room containing a harmless caged snake and to approach, touch, and pick up the animal. Observers gave the clients avoidance scores on the basis of whether the clients were able to look at, touch, or hold the snake. Many other fear stimuli, including rats, spiders, cockroaches, and dogs, have since been used in BATs that present those stimuli live, on video, or through virtual reality systems, and the "look–touch–hold" coding system for scoring responses has been replaced by more sophisticated measures.

In Review Approaches to Observational Assessment

Types	**Characteristics**	**Advantages and Disadvantages**
Naturalistic (participant or nonparticipant observers; self-monitoring; unobtrusive measures)	Behavior is observed where it normally takes place (home, school, hospital). Observers may be visible or hidden clinical personnel, teachers, family members, or clients themselves (self-monitoring). Analysis of school grades, medical records, etc.	+ Data not distorted by artificial or unfamiliar situations (higher ecological validity). – Behavior can be affected by uncontrolled circumstances. –Self-monitoring may be distorted by efforts to hide undesirable behavior.
Controlled (performance tests; role-playing; staged events; behavioral avoidance tests)	Behavior is observed in situations created by the clinician or researcher.	+Avoids interference from uncontrolled events; assures that behavior of interest will be observed. –Behavior observed in artificial situations may have lower ecological validity.
Test Yourself		

1. Because thoughts cannot be observed by others, the best way to collect observational data on the frequency of a client's depressive thoughts is through ________.

2. Using virtual reality systems to assess client reactions to specific stimuli or situations is a form of ___________observation.

3. Arranging for a clinical assistant to talk to a client at a shopping center to assess the client's social skills combines ________ and ________ observation.

You can find the answers in the Answer Key at the end of the book.

Research on Observational Assessment

Section Preview As described in the previous section, many kinds of observational assessments have high levels of ecological validity, but they also have limitations. Observers are more likely to disagree when they are not looking for the same sets of behaviors and coding them in the same way. It is therefore important for behavioral targets to be specified, coded, and recorded clearly. As with interviews, reliability is also improved when there are clear inference rules about what recorded observations mean. Of particular concern in observational assessment are clinician biases, often unrecognized because observations seem to be so objective. Clinicians should cross-validate conclusions on the basis of observations with those drawn from other assessment data. In clinical practice, controlled observational assessments are frequently not conducted as much because of the time and effort required; brief structured observations are often preferred in today's health-care environment.

Behaviorally oriented clinicians are typically the most enthusiastic proponents of observational assessment. They argue that observations provide the most accurate and relevant source of assessment data. Observations have even been likened to photographs in that they are thought to provide a clear and dispassionate view of human behavior. But as any photographer knows, a photograph is not just a rendering of a scene; it is but a combined product of scene elements, the photographer's choices about equipment and framing, and judgments made during the photo editing

process. Similarly, a number of factors can influence the reliability and validity of observational assessment.

Defining Observational Targets

A fundamental requirement for establishing both the reliability and validity of observational assessment is clarifying the target to be measured. Decisions about what aspects of behavior to look for and code, and how these targets are defined, reflect the clinician's or researcher's view of the presence and meaning of an observation. Consider assertiveness. One clinician might assess assertiveness by observing clients' ability to refuse unreasonable requests, whereas another might focus on the direct expression of a preference for a particular restaurant table. This problem of definition may never be resolved to everyone's satisfaction, but evaluating the reliability and validity of an observational system begins with questions about what behavioral features are to be coded.

Representativeness of Observed Behavior

Clinicians using observational assessment must also be concerned about the possibility that clients under observation will intentionally or unintentionally alter the behaviors that are of greatest clinical interest. The observation situation itself can exert an influence on client behavior through social cues, or *demand characteristics* (Orne, 1962), that inadvertently suggest what actions are, or are not, appropriate and expected. Thus, if a clinician observes a couple in a setting that contains strong social cues about how the clients should behave (e.g., “We would like to measure just how much fighting you two actually do”), the observation may reveal a degree of conflict that is unusually high (or low) for that couple. For example, in a study designed to measure assertiveness, college students were asked to respond to audio recordings that portrayed various kinds of social situations (Nietzel & Bernstein, 1976). The assertiveness of their responses was scored on a 5-point scale. All subjects heard the tape twice, under either the same or differing demand situations. The “low-demand” situation asked participants for their “natural reactions,” but in the “high-demand” situation, they were told to be “as assertive as you think the most assertive and forceful person could be.” The results showed that participants on the first test behaved more assertively if they heard high-demand instructions than if they heard low-demand instructions. And as you might expect, if instructions remained the same on the second test, participants remained about as assertive as they were the first time. However, if the instructions encouraged more assertiveness on the second test than on the first, participants behaved more assertively. Similarly, participants who heard high-demand instructions the first time

behaved less assertively if they heard low-demand instructions on the second test. In short, participants' assertiveness was significantly influenced by what they thought they should do in the assessment situation. Other research on observational anxiety assessment has shown that the instructions given, the presence or absence of an experimenter, the characteristics of the physical setting, and other situational variables influence the amount of fear clients display during behavioral avoidance tests (e.g., Bernstein, 1973; Bernstein & Nietzel, 1977).

Various strategies have been suggested to minimize situational bias in observational assessment (Bernstein & Nietzel, 1977; Borkovec & O'Brien, 1976), but the problem cannot be entirely eliminated. As long as the stimuli present when the client's behavior is being observed differ from those present when the client is not being observed, we cannot be sure that the behavior displayed during formal observation is representative of that which occurs in other situations. The best that clinicians and researchers can do is minimize the strength of cues that might influence client behavior. Utterly naturalistic or unobtrusive observation is theoretically possible, but often not practical. Accordingly, clinicians and researchers will continue to rely on contrived, analog observations to assess some behavioral targets.

Reliability of Observational Assessment

To what extent are observational assessments reliable? Test–retest reliability can be difficult to measure if clients' behaviors change substantially over time. For example, if couples show hostility and considerable anger when discussing a topic during one observation but display much less of these emotions a week later, measures of hostility across sessions will be considerably different (Heyman, 2001). This problem, combined with the fact that the repeated measures needed to establish test–retest reliability can be time-consuming and expensive, interrater reliability is often the preferred standard.

Interrater reliability is strongly influenced by two main factors: task complexity and rater training. Reducing *task complexity* often increases interrater reliability (e.g., reliability can be increased if the observers use a 15-category rather than a 100-category coding system). The effects of *observer training* are even more obvious. If observers intend to record laughter, for instance, but are not given a clear definition of what is meant by "laughter," one observer might count belly laughs but not giggles, whereas another might include everything from smiles to violent guffaws. Finally, when people are first trained to use an observation system, they usually work hard during practice sessions and pay close attention to the task, partly because they are being evaluated. Later, when "real" data are being collected, the observers may gradually become careless, especially if they think that no one is checking their reliability (Taplin & Reid, 1973). This phenomenon of "rater drift" can adversely affect the quality of observational research

(Sgammato & Donoghue, 2018). Accordingly, supervision of people doing observation and coding is sometimes necessary.

As with interviews, the highest levels of interrater reliability are associated with empirically-derived clinical observation assessment systems that use trained observers. These systems can provide reliability coefficients in the 0.80 to 0.90 range (Antony & Barlow, 2010; Harwood, Beutler, & Groth-Marnat, 2011). Less-structured observations tend to have lower reliability, almost surely because they require more subjective judgments on the part of observers.

Validity of Observational Assessment

At first glance, observation of behavior would appear to rank highest in validity among all clinical assessment approaches. After all, if we observe aggression in a married couple, are we not assessing aggression, and is that not enough to establish the validity of our technique? The answer is yes only if we can show that: (a) the behaviors coded (e.g., raised voices) constitute a satisfactory demonstration of aggression; (b) the data faithfully reflect the nature and degree of aggression occurring during observation; and (c) the clients' behaviors being observed accurately represent their typical behavior in related, but unobserved, situations.

One way to assess the validity of observations is to ask about the extent to which the resulting conclusions correlate with conclusions drawn from other assessment methods. For example, does the ability to refuse unreasonable requests occur more often in people judged to be assertive by their peers? If so, then the peer judgment correlates with the observation, and we can say that the observation has shown convergent validity. The more an observation correlates with other data, such as interviews, physiological measures, self-reports, and others' appraisals, the greater the convergent validity of the observation (e.g., Andersson et al., 2013).

If the observational assessment accurately forecasts behavior, such as whether a client with a brain injury will be able to drive safely (e.g., Lew et al., 2005), we can say that the observational assessment has *predictive validity*. Not surprisingly, observations that involve clearly defined targets and sample repeated instances of behavior under realistic conditions tend to have higher predictive validity compared with other observations. In one

study, researchers collected observations of preschool children's behaviors and mothers' reports of their children's behaviors. They found that the observational measures did a better job than the mother's reports at predicting children's behaviors 4 years later (Zaslow et al., 2006).

Today, clinicians and researchers can choose from a large and rapidly growing array of observational assessment instruments. Many of these instruments are brief, focus on well-defined symptoms or behaviors, and have reasonably well-established reliability and validity; many others have yet to be thoroughly validated. The validation process can be slow because there is no gold standard against which to compare newly developed observational instruments and thereby establish their validity (Lang & Kleijnen, 2010). As a result, clinicians and researchers faced with so many choices can be uncertain about which ones are best for particular assessment purposes.

In Review Research on Observational Assessment

General Factors Affecting Value of Observational Assessment	**Examples**
Target clarity	Targets of observation must be clearly defined and consistently coded.
Representativeness (ecological validity)	Social behaviors observed when a client has a bad cold are not likely to be as typical of that client's behavior when healthy.
Social influence (demand characteristics)	Clients are more likely to show intense fear during a BAT if the test is described as a test of fear than as a test of, say, human–animal communication.
Measuring the reliability of observational assessment	Test–retest: Can be reduced by changes in client behavior across time. Interrater: Reduced by high task complexity and lack of observer training.
Measuring the validity of observational assessment	Ecological: Does observed behavior accurately represent client's behavior in other situations? Convergent: correlation between observational data and evidence from other sources (e.g., family). Predictive: Does observational data accurately forecast client's behavior?

Test Yourself

1. A 10-category observational coding system is likely to produce _______ interrater reliability than a 25-category system.

2. Interrater reliability tends to _______ as teams of observers continue to use a coding system over time.

3. Asking observers to code as “violence” anything a person does without smiling would probably lead to data that has _____ interrater reliability but _____ predictive validity.

You can find the answers in the Answer Key at the end of the book.

Chapter Summary

Interviews are defined as conversations with a purpose, and in clinical situations, these purposes include client intake, problem referral, orientation, termination, crisis intervention, and observation. In nondirective interviews, the clinician interferes as little as possible as the client talks, whereas structured interviews present planned inquiries in a fixed sequence. Semistructured interviews fall between these extremes.

Most interviews have three main sections. Intake and problem identification interviews, for example, usually begin with efforts at making the client comfortable, enter an information-gathering middle stage, and end with a summary and discussion. Conducting each phase of an interview and moving smoothly from one to the next requires a combination of good interpersonal judgment, active listening skills, well-phrased questions, and tact. If interviews are to have maximum value, communication between client and interviewer must be as clear as possible in both verbal and nonverbal channels, and minimally affected by personal and cultural biases.

Although the reliability of interviews, especially structured interviews, is generally good, it can depend on several variables, including how questions are phrased and the client's comfort with the interviewer, emotional state, memory skills, and motivation. Both reliability and validity can be threatened by interviewer errors or biases, especially those relating to preconceived views of clients with particular characteristics. Eliminating such errors and biases is a major challenge for clinicians. There is some evidence that adding unstructured interview information to data from other assessment sources can

decrease the validity of clinicians' overall judgments, so practitioners shouldn't assume that interviews always enhance assessment validity.

Observational assessment systems are designed to collect information about clients that is not available from other sources or that corrects for biases inherent in other sources (e.g., biases in self-reports). Observation can be conducted in naturalistic or controlled settings (or some combination of the two) by participant or nonparticipant observers. Sometimes, clients are asked to observe and record their own behavior, a procedure called self-monitoring.

Naturalistic observation systems have been developed for many settings, including hospitals, schools, and homes. They have the advantage of realism and relevance, but they are expensive and time-consuming and may be affected by uncontrollable situational factors. To minimize these problems, clinicians use controlled observations—special circumstances under which clients can be observed as they react to standardized events—including role-played social interactions and performance tests of smoking, eating, drinking, or dealing with a feared object or situation. During controlled observation, clinicians may monitor clients' physiological as well as overt (observable) responses.

Although observation gets around some of the inference problems that reduce the reliability and validity of many interview and test procedures, it is not a perfect assessment tool. For one thing, data from observational assessments can be influenced by factors other than the behavior of clients. The reliability and validity of observational data hinge on the precise definition of observation targets, the training and monitoring of observers, efforts to guard against the effects of observer bias, reactivity in the

observation process, and situational influences such as demand characteristics that might create unrepresentative samples of client behaviors.

5

Testing in Clinical Psychology

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Contents

Basic Concepts in Psychological Testing

Tests of Intellectual Functioning

Tests of Attitudes, Interests, Preferences, and Values

Tests of Psychopathology and Personality

The Current Status of Psychological Testing

Chapter Preview

In this chapter, we consider the nature of psychological tests, how tests are constructed, and how clinical psychologists use—and misuse—them. Most psychological tests can be categorized as measuring (a) intellectual abilities; (b) attitudes, interests, and values; or (c) aspects of personality, including psychopathology. Tests can also be categorized according to the kinds of responses requested—some ask for brief, easily scored responses (such as true or false), whereas others require longer, more difficult-to-score responses (such as stories or drawings). We describe the tests that are most commonly used by clinicians and provide information about their psychometric properties and clinical utility. We conclude the chapter with a summary of recent developments in psychological testing.

As we describe in Chapter 2, psychological testing is an activity that helped define clinical psychology, but its popularity has had its ups and downs over the years. Beginning early in the 20th century and continuing through the mid-1960s, tests were seen by many as semi-magical pathways to the "truth" about intelligence, personality, interests, abilities, and various other characteristics (Reisman, 1976), and clinical psychology students received intensive training in using them. From the late 1960s through the 1970s, however, testing lost much of its appeal and was not as strongly emphasized in clinical training or in clinicians' professional work.

Four factors led to the decline of testing during this period. The first was the discouraging results of research on the reliability and validity of many psychological tests. The second was concern that test results can

be vulnerable to systematic error, or *bias*. That concern focused especially on the possibility that standard tests of intelligence might discriminate unfairly against people in certain racial or ethnic groups. A third factor was the fear that testing might result in an invasion of respondents' privacy. The fourth centered on worries that test results can too easily be misinterpreted and misused.

More recently, though, psychological testing has recovered some of its status and popularity; it is now a regular part of most clinicians' training and professional activities. One reason for this resurgence is that, as we will describe later in this chapter, new and better tests have been designed to address some of the concerns we just mentioned. A second reason is that many of today's educational and health-care systems now routinely require psychological testing (Youngstrom, 2013).

What do tests measure? Psychological tests are used to measure everything from A (anxiety) to Z (z-scores on tests of zoophobia). In fact, as we mention in Chapter 2, there are so many tests that it takes special publications to list them all and review their reliability, validity, and utility (or usefulness). The best known and most authoritative of these publications is the *Mental Measurements Yearbook*, first published in 1938 (Buros, 1938) and updated frequently (Carlson, Geisinger, & Jonson, 2017). Many of the thousands of tests listed in such publications can be purchased from their publishers only by qualified individuals. This restriction is designed to keep test items confidential, much as professors try (often unsuccessfully) to keep their exams under wraps. Other tests are freely available to researchers or other interested people. In 2011, the American Psychological Association created PsycTESTS, a

searchable database where professionals can gain access to information about, and download copies of, thousands of psychological tests, many of which are unpublished (Weir, 2012).

There are tests designed to be used with infants, children, adolescents, adults, senior citizens, students, military personnel, mental patients, office workers, job applicants, prisoners, and just about every other imaginable group (Plake et al., 2012). Some of these tests pose direct, specific questions ("Do you ever feel discouraged?"), whereas others ask for general reactions to less specific material ("Tell me what you see in this drawing"). Some have correct answers ("Is a chicken a mammal?); others ask for opinions or preferences ("I enjoy looking at flowers: true or false?"). Some are presented on paper or a computer screen, and some are presented orally. Some require verbal skill ("What does *analogy* mean?"), some involve nonverbal tasks ("Please trace the correct path through this puzzle maze"), and still others combine verbal, numerical, and performance items. Often, there are many different tests that purport to measure the same characteristic. For example, a clinician can choose from at least 280 measures of depression (Fried, 2017). Having so many tests available can create challenges for practitioners and researchers alike, especially because there may not be much overlap in the content of different instruments that are supposed to be measuring the same thing (Marsh et al., 2003). In some cases, their results may not even correlate very much with each other.

One reason for the vast number of tests is that testers are constantly trying to measure psychological characteristics in more reliable, valid, and sophisticated ways. Another reason is that testers are becoming interested in more specific characteristics, which stimulates the

development of more and more special-purpose tests. Despite their enormous variety, tests can be grouped into three general categories based on whether they seek to measure: (a) *intellectual or cognitive abilities*; (b) *attitudes, interests, preferences, and values;* or (c) *personality characteristics*. The tests most commonly used by clinical psychologists in the United States and elsewhere are those that measure intellectual functioning and personality (Camara, Nathan, & Puente, 2000; Harwood, Beutler, & Groth-Marnat, 2011; Wright et al., 2017). That's because these variables are especially relevant to most clinicians' treatment and research activities, and also because clinicians have long been expected to conduct this kind of testing (Benjamin & Baker, 2004).

Try this If you have not already done so, google Buros Center for Testing, where you can get an idea of the impressive range of tests available to clinicians today. Many of these tests are also available to the public at websites such as *Psychtests* where you can take them online for free, but you have to pay for (usually unscientific and potentially misleading) reports on what they say about you. Such sites are not to be confused with the APA's psycTESTS research database.

Basic Concepts in Psychological Testing

Section Preview In this section we will describe the basic nature of psychological tests and how they resemble and differ from other forms of assessment. We will explain how tests are constructed and list the basic requirements for a good test: adequate norms and standardization, reliability, validity, and utility. We will also focus on how those who develop and use tests can minimize the likelihood of generating biased results.

What Is a Psychological Test?

A **psychological test** is a systematic procedure for observing and describing a person's behavior in a standard situation (Cronbach, 1970). Tests present a set of planned stimuli (factual questions, inkblots, or true–false questions, for example) and ask the client to respond in some way. The clinician then scores or interprets the client's responses using reasonably objective, empirically derived scoring rules, meaning rules that are based on empirical data. As we mention in Chapter 3, the clinician might incorporate test results into an overall assessment report that may also include information derived from interviews, life history records, behavioral observations, and other sources.

Psychological test

A systematic procedure for observing and describing a person's behavior in a standard situation.

Our description of tests highlights two of their most important features. First, tests are ideally designed to be *objective* measures of psychological characteristics. So just as a ruler is designed to be an objective measure of length no matter who uses it, tests should give the same or at least similar results no matter who conducts the testing. The goal is to ensure that the differences among clients' test scores reflect differences among the clients themselves, not differences among the clinicians who tested them. Our description also highlights the need for test *standardization*. Everyone who

takes the same test should be exposed to the same set of materials and evaluated according to the same scoring criteria. You can appreciate the importance of standardization by imagining an IQ test that consists of only one item, and that item is different for each client. Suppose now that one 5-year-old answers correctly when asked "What part of your body goes in your shoe?" and another one says "six" when asked "How many quarters make two dollars?" How could we determine if the difference in their test results reflected a difference in their intelligence or a difference in the test item they happened to encounter? We couldn't.

The principles of objectivity and standardization allow us to evaluate the quality of psychological tests using the same logic that we apply to evaluating the quality of psychological experiments (Domino & Domino, 2006). In both cases, the idea is to reduce or eliminate the impact of extraneous, or confounding, variables—such as scoring procedures or the tester's personal characteristics—so that test results can be attributed to just one source, namely the characteristics of the client.

In other words, tests are similar to experiments, but they also resemble the highly structured interviews or behavioral observations we discuss in Chapter 4, because they ask clients to respond to specific items in a predetermined sequence, and those responses are scored on the basis of explicit rules. Another sense in which tests share characteristics with observational assessments is that they provide an opportunity for the clinician to watch the client in the test situation. However, tests differ from most other clinical assessment techniques in three ways:

1. Usually, a client's test responses can be quantitatively compared with statistical *norms* established by the responses of hundreds or thousands of

other people who have taken the same test under standardized conditions. Having these norms is a key principle in psychological assessment. They provide baselines that allow us to compare a given client’s responses with those of other people, and not just any other people. Many psychological test manuals contain norms for various groups, such as those of different ages or genders. When norms are absent or don’t adequately represent the population from which the client comes, a clinician can draw incorrect conclusions about the client’s test results. *Standardization*, in turn, ensures that everyone who takes a test receives the same instructions and experiences the same (or very similar) testing conditions. Norms and standardization allow us to more confidently compare a particular 5-year-old’s test performance with that of the average 5-year-old.

2. A test can be taken in private, without a clinician present, meaning that there might not be observational data to supplement test results.

3. Tests can be administered in groups as well as individually.

High-Stakes Testing

The SAT and other college entrance examinations provide examples of how tests are used to assess large numbers of people at the same time.

(Source: Martin Bureau/Staff/AFP/Getty Images.)

How Are Tests Constructed?

The seemingly odd items on some psychological tests, especially on certain personality tests, understandably lead many people to wonder how psychologists come up with these things. The answer is that they usually construct their tests using either *analytic* or *empirical* approaches, though often they use a *sequential system* approach, which combines the two (Burisch, 1984).

Psychologists who take an **analytic approach**, sometimes called the **rational approach**, begin by asking: What are the qualities we want to measure, and how do we define them? They then build their test by creating items that answer these questions. In other words, analytic test developers chose materials or items by analyzing the content of a domain and then writing questions that they believe (or that a theory suggests) should assess that content.

Analytic approach (rational approach)
A test construction procedure in which items are chosen because they appear on logical grounds to measure the characteristic of interest to the tester.

To illustrate the analytic approach, suppose that a research team wants to develop a test of racial prejudice. Their first step would be to ask themselves what kinds of test items are likely to be answered differently by people who

are and are not prejudiced. The items they write, then, will be shaped by what their knowledge, experience, and favorite theories, and perhaps previous data say should be different about prejudiced and unprejudiced people. If they adopt a trait theory of personality, they may assume that the most important differences should appear in people's longstanding personality dispositions and attitudes. As a result, they might write a true–false test containing items like these:

1. I think some races are smarter than others. T__ F__

2. Equal opportunity in housing and employment is important. T__ F__

3. There are too many government programs to help minority groups. T__ F__

4. Racial diversity improves the performance of groups in the workplace. T__ F__

If the clinicians favor a psychodynamic theory, they would probably want to measure prejudice at an unconscious level. Their test might search for unconscious themes by asking clients to fill in incomplete sentences like these:

1. Some groups of people _____________.

2. Criminals are usually _____________.

3. The trouble with society today is _____________.

4. Life is too easy for _____________.

This example illustrates the fact that analytically constructed tests of the same concept will differ significantly depending on the testers' definition of that

concept, what aspects of it they think are most important, and how they think it is best measured (see Figure 5.1).

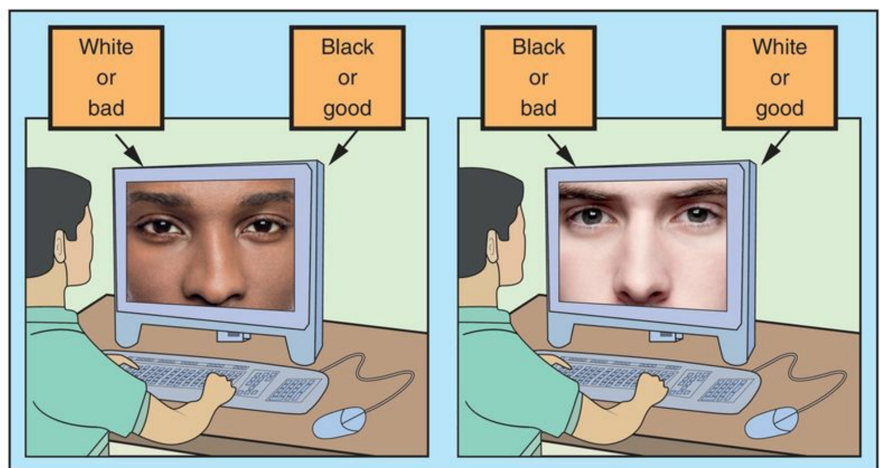

Figure 5.1 The Implicit Association Test (IAT)

Try this The IAT measures attitudes and beliefs that people may be unwilling or unable to report by recording how quickly they come to associate pairs of words (such as "science" and "men," vs. "science" and "women") or to associate images with words (such as "good" with light-skinned vs. dark-skinned faces). If you visit Project Implicit at https://implicit.harvard.edu/implicit/selectatest.html, you can learn more about the IAT and use it to measure your own implicit attitudes about race, gender, sexuality, disability, age, and many other topics. At Project Implicit Mental Health (www.ImplicitMentalHealth.com) you can complete IATs tied to anxiety, depression, therapy, stigma of mental illness, suicide, and other mental health topics. Were the results you received at these sites consistent with how you think about yourself?

The main alternative to analytic test construction is the **empirical approach**. As we mentioned earlier, *empirical* means *data-based*, so instead of deciding ahead of time what test content should be chosen to measure a particular target, testers who employ an empirical approach allow data to

guide their choice of items. Using this approach to develop a test of prejudice, our team of clinicians would first collect a large number of true–false, fill in the blanks, multiple choice, and other kinds of self-report items, perhaps along with various performance tasks, inkblots, or other test materials. They would then administer these materials to a large group of people *who have already been identified* as prejudiced or unprejudiced on the basis of criteria such as features of their online presence, social media posts, group memberships, and the like. The clinicians would then examine everyone's responses to all these testing materials to see which items, tasks, or other stimuli were consistently answered differently by people who had been classified as prejudiced versus unprejudiced.

Empirical approach
A test construction procedure in which items are chosen on the basis of whether people who differ in some way respond differently to them.

After careful statistical analysis, any test items that significantly differentiate the two groups would then be used to create the initial version of the prejudice test, *regardless of whether those items bear any obvious relationship to prejudice.* So if many more unprejudiced people answered "true" to items such as "I often have trouble sleeping" or "My shoes are too tight," those items would become part of the test. This purely data-based selection procedure helps to explain why some tests contain items that are

apparently so peculiar. These items are said to have low “face validity,” meaning that on their “face” they don’t seem to have anything to do with the psychological concept of interest (Nevo, 1985). But such items have a potential advantage: Because of their apparent irrelevance to, say, prejudice or anxiety, they are hard to “figure out” thus making it more difficult for respondents to create false impressions. Their potential disadvantage is that they may be less effective when compared to items with high face validity (Weed, Ben-Porath, & Butcher, 1990).

The choice of analytic versus empirical test development procedures is usually shaped by factors such as time, money, and theoretical preferences. The analytic approach can be faster and less expensive because it does not require the test developer to pre-test many items with many people before settling on the ones that will comprise the test. So analytic procedures are attractive to researchers and clinicians who don’t have access to a large pool of test material and hundreds or thousands of willing pre-test participants. These procedures are also ideal for psychologists who for some reason need to develop a test on short notice, and especially for those who will use their test to evaluate a hypothesis based on a particular theory. Suppose, for example, there is a theory that includes “geekiness” as an important personality dimension. If there is no “geekiness” test available, researchers will probably use the analytic approach to create one. They will write test items that appear to assess the characteristics that the theory says define geekiness.

Researchers and clinicians who have time and other resources available may find the empirical approach more desirable, especially when attempting to make specific predictions about people. Suppose the task is to predict which applicants for a clinical psychology training program are most likely to

complete their Ph.D.s within 6 years. In a case like this, it makes sense to find out if there are test items that are responded to differently by students who graduated within the six-year time frame and those who dropped out or took extra time.

In short, the analytic method often results in items that appear sensible but may or may not work; the empirical approach often results in items that work but may not appear sensible. The **sequential system approach** to psychological test construction combines aspects of analytic and empirical techniques. The decision about which items to try is usually made on analytic grounds; some items are selected from existing tests, whereas others are those the test designer believes "ought" to be evaluated. After using the analytic approach to choose items for the initial version of the test, the testers use an empirical approach to refine it. This process requires trying out the items with a group of people and examining the results to determine which items were answered differently by people who are already known to differ on the characteristic of interest. They may also look at which items are correlated with one another, the ones that all tend to be responded to in similar ways by people who are, say, depressed or anxious or optimistic. Groups of correlated items, known as *scales*, are often assumed to be relatively pure measures of certain dimensions of personality, cognitive ability, or the like (Maloney & Ward, 1976). As we point out in Chapter 3, however, no matter how a test is constructed, its value as an assessment instrument ultimately depends on the results of scientific research on its reliability, validity, and utility.

Sequential system approach

A test construction approach that combines aspects of analytic and empirical techniques.

Standardization and Score Interpretation

We have already said that standardization refers to consistency in the administration and scoring of a test. Ideally, tests are given in the same way to every person who takes them.

Standardization, Within Reason

It is important to set up standardized testing conditions, but there is no point in taking this ideal to extremes. We know of a professor who, during practice sessions in his intelligence-testing course, walked around the room with a ruler to confirm that his students placed certain stimulus materials

directly in front of their client and exactly 7 inches from the edge of the table.

(Source: BSIP SA/Alamy Stock Photo.)

Test standardization can also refer to the sample on which the test was developed. To illustrate, Dr. Cynthia Leon, the psychologist you met in Chapter 1 when she began working with Rachel Jackson's family was asked to give an IQ test to Rachel's 12-year-old brother, Jamal. She finds that he is correct on 14 out of 25 items on a memory test. Is that a high score? A low score? Is it somewhere in between? To answer this question, Dr. Leon must compare Jamal's score with existing norms. Specifically, she would compare Jamal's scores with those earned on the same test by a **standardization sample** of thousands of other 12-year-olds. If only 8% of them scored at 14 or higher, Dr. Leon would know that Jamal did better than 92% of the standardization sample, marking his score as quite high—at the 92nd percentile to be exact.

Standardization sample
A group of people who have already taken a particular test and whose scores provide a baseline against which later respondents' scores can be compared.

Every decade or so, most major psychological tests are re-normed, meaning that data from a new standardization sample is collected to ensure

that the norms are up to date. This process can be complex and expensive because it involves identifying a large, representative sample of people willing to take the test; finding examiners to give the test and report the scores; and compiling and analyzing all the data. The results of this re-norming process are then usually published in the instruction manuals that accompany the tests. It was by consulting such a manual that Dr. Leon was able to interpret Jamal's scores. After giving a test, clinicians compare their client's scores with those contained in the manual.

Most of the tests that we describe in this chapter are norm-referenced tests, but test scores can also be interpreted based on a *criterion* established by the tester rather than on a normative sample. If you have a driver's license, you have taken a criterion-referenced test. The government agencies that certify drivers aren't interested in how good a driver you are compared to other drivers; they want to be sure that you can meet certain minimum criteria, such as knowing the rules of the road, steering and turning safely, and parallel-parking properly.

Test scores can also be interpreted by comparing a person's score, not to other people's scores or to an external criterion, but to the person's own scores. This process is often called *ipsative measurement*. Tests designed to measure progress in psychotherapy, for example, might ask clients to list their most important goals for the next year or estimate the number of panic attacks they have experienced in the past month. It can be informative to compare the results of such tests at the beginning of therapy to those collected at various points during treatment (Finn & Hale, 2013).

Avoiding Distortion in Test Scores

Many factors can influence the outcome of psychological tests. A classic example is provided by a study in which male college students viewed photographs of nude females and then took a personality test. The students gave more sex-related test responses if the photographs had been presented by a young, casually dressed male graduate student than if the photos had been presented by a professorial older man wearing a jacket and tie (Mussen & Scodel, 1955). The circumstances under which a test is given—anything from temperature extremes and noise to crowding and the presence of a stranger—can also affect its results (Plante, Goldfarb, & Wadley, 1993). In one case, a child's scores on repeated IQ tests went from 68 to 120 and back to 79 depending on whether a certain adult was present during the test (Handler, 1974). In another case, researchers found that adults who were asked to draw a man were more likely to include a mustache if the examiner had one than if he was clean-shaven (Yagoda & Wolfson, 1960).

Test results can also be distorted by the tendency for some clients to respond in certain ways to most or all items, regardless of item content. This long-recognized tendency has been called a *response set* (Cronbach, 1946), *response style* (Jackson & Messick, 1958), or *response bias* (Berg, 1955). Clients are said to display an *acquiescent response style* (Jackson & Messick, 1961), for example, if they tend to agree with virtually any self-descriptive test item (such as "I am self-confident," "I am fearful," "I am submissive"). Clients exhibiting a *social desirability bias* will respond to test items in ways that are most socially acceptable, whether or not those responses reflect their true feelings, attitudes, or impulses (Edwards, 1957; Rychtarik, Tarnowski, &

St. Lawrence, 1989). Sometimes, of course, clients give untruthful responses so as to intentionally create false impressions; depending on their goals, they may try to appear healthier or more severely disordered than they really are. This form of distortion is called *malingering*, and it can be a serious problem, especially when test scores can affect the outcome of criminal proceedings, custody evaluations, involuntary commitment, personal injury litigation, and the like (Larabee, 2012). As you will see later in this chapter, many tests include sets of items that are specifically designed to detect response bias and malingering.

There is some debate about the extent to which response styles and biases can distort test scores, and whether they reflect temporary strategies triggered by the circumstances of testing, or stable personality characteristics (Linehan & Nielsen, 1983; McCrae & Costa, 1983; Merckelbach, et al., 2019; Stewart et al., 2010). For example, the tendency to respond “true” to socially desirable items, such as “I am a good person,” may occur because of a person’s genuinely high self-esteem, not a response bias (McGrath, Mitchell, Kim, & Hough, 2010). Whatever the case, the client’s point of view while taking a test cannot be ignored when evaluating test results.

It is impossible to eliminate all factors that can potentially distort test scores, but test designers try to minimize them by: (a) developing clear, simple instructions to guide examiners and test takers; (b) conducting extensive trials of their tests that can reveal response tendencies on particular items; (c) seeking advice from experts on test bias to help them flag potential problems; and (d) incorporating item sets that can detect the operation of response bias or deliberate distortion. This last strategy might take the form of including a few bizarre or implausible items (e.g., “I have never sneezed”)

to ensure that respondents are paying attention and being honest (Marcus et al., 2018).

The clinicians who give psychological tests can also play a part in reducing response distortion by: (a) clearly explaining the purposes of the test and answering any questions the client has, thereby enhancing rapport and client motivation; (b) paying careful attention to the circumstances under which testing takes place so that conditions are essentially the same for every client; and (c) taking note of any circumstances during testing that might have compromised the value of the test results (Ayearest & Bagby, 2010).

In Review Basic Concepts of Psychological Testing

What is a psychological test?	A systematic procedure for observing and describing a person's behavior in a standard situation. They are meant to be objective and standardized.
What do psychological tests measure?	Intellectual or cognitive abilities. Attitudes, interests, preferences, and values. Personality characteristics. Psychological disorders or problems in living.
How are psychological tests constructed?	*Analytically*: Based on what items seem sensible to include. *Empirically*: Based on which items are answered differently by people who differ on some characteristic of interest. *Sequentially*: Choosing items analytically, and then evaluating them empirically.
How are psychological tests interpreted?	A client's scores on a norm-based test are compared with the average scores in a large standardization sample of people who have taken the test in the past. A client's score on a criterion-based test is interpreted in relation to some fixed standard, regardless of the scores earned by others in the past.
What factors can distort psychological test scores?	Non-standard test administration. Response styles or biases. Intentional deception.
What criteria	*Norms*: Measures of central tendency and variability for

are used to evaluate the value of psychological tests? (See Chapter 3 for more details)	the test obtained from a large, representative standardization sample; these allow meaningful interpretation of scores. *Internal consistency*: A measure of reliability, usually accomplished by the split-half method. *Test–retest reliability*: Similarity of results from repeat testing of the same people. *Interrater reliability*: Similarity of results when multiple raters independently score the same tests. *Content validity*: Test items adequately sample all important domains associated with the trait or ability being measured. *Convergent validity*: Results of the test correlate with other well-established measures of the same construct. *Discriminant validity*: Results of a test do not correlate with measures of constructs that are conceptually different. *Diagnostic or clinical utility*: The degree to which test results clearly point to specific diagnoses or preferred treatments, or can reliably measure changes that result from treatment.

Test Yourself

1. If a test is designed to be administered in whatever way a clinician thinks is best, that test would not be __________.

2. If a test contains items that don't appear related to what the test is supposed to measure, it was probably constructed using an __________approach.

3. A client who fakes test responses in order to create a false impression is said to be _____________.

You can find the answers in the Answer Key at the end of the book.

Tests of Intellectual Functioning

Section Preview In this section, we first consider how theorists have tried to understand cognitive abilities collectively known as intelligence. You will then see how clinicians measure these abilities using intelligence tests such as the Stanford–Binet scales and the Wechsler scales. We conclude the section with a look at tests designed to measure achievement and aptitude.

Theories of Intelligence

Everyone agrees that intelligence is a good thing to have, but what exactly is it? Psychologists have never been able to agree on a precise answer to this question (Davidson & Kemp, 2011), but the vast majority of them tend to agree that **intelligence** includes three main characteristics: (a) abstract thinking or reasoning abilities (such as manipulating symbols and concepts); (b) problem-solving abilities that are adaptive for survival; and (c) the capacity to acquire new knowledge; that is, to learn (Gottfredson, 1997; Snyderman & Rothman, 1987).

Intelligence
Cognitive abilities that include abstract thinking and reasoning, adaptive problem-solving, and capacity to learn.

Researchers who take an *information-processing* approach to the concept try to identify the mental *processes*—such as attentional focus and visual perception—that are involved in intelligent behavior (e.g., Ackerman, Beier, & Boyle, 2002; Jensen, 1993; Sternberg, 2011), but how do they know what behaviors count as "intelligent?" The half-joking suggestion among psychologists, many of whom despair of finding a clear-cut definition, is that "intelligence is whatever intelligence tests measure" (Boring, 1923). Indeed, researchers who take a *psychometric*, or mental measurement, approach to studying intelligence focus on the "products" of intelligence, including

academic grades, job performance, and especially scores on intelligence tests. The developers of most of those intelligence tests built them using analytical procedures, meaning that they chose items that reflected their own theories about what intelligence is and how best to measure it. A detailed description of those theories is beyond the scope of this chapter, so we encourage you to consult any of several excellent reviews for more information (e.g., Davidson & Kemp, 2011; Goldstein, Princiotta, & Naglieri, 2015; Rowe, 2013).

Here, we will just summarize three main psychometric approaches, usually referred to as the *general intelligence*, *multiple intelligences*, and *hierarchical and factor-analytic* models. Each of these approaches provides different, though related, answers to the question of whether intelligence is one general trait or a bundle of more specific abilities. The answer matters, because if intelligence is a single trait, then an employer might assume that someone with a low intelligence test score could not do any tasks well. But if intelligence is composed of many somewhat independent abilities, then a low score in one area would not rule out the possibility of good performance in others.

General Intelligence. Originally proposed early in the 20th century by Charles Spearman (1904), the notion of intelligence as a global, general ability—usually referred to as g—was based on the observation that almost all tests of cognitive ability are positively correlated (van der Maas et al., 2006). If you do well on one test, you are likely to also do well on all of the others. People's cognitive abilities can vary somewhat across different domains, but *g* is presumed to be an underlying biological or psychological trait that influences them all. The general intelligence view is further supported by the fact that students who are exceptionally good in math, for

instance, also tend to be good in language, biology, and many other disciplines.

Multiple Specific Intelligences Models. Although scores on a variety of cognitive tasks are positively correlated, the correlations are not always high. As a result, some researchers—including Spearman himself—have suggested that what appears to be general intelligence is actually made up of a collection of relatively separate, more specific abilities. As many as 120 of these *specific* intellectual functions (called *s*'s) have been proposed, including word fluency, short-term memory, and perceptual speed (Carroll, 1993; Domino & Domino, 2006), but most theories suggest that *g* is composed of seven or fewer specific mental abilities (e.g., Thurstone, 1938).

The idea of multiple aspects of intelligence figures prominently in Robert Sternberg's *triarchic theory of intelligence.* According to Sternberg, there are three basic kinds of intelligence—analytical, creative, and practical—and he says that conventional intelligence tests focus mainly on the first kind (Sternberg, 2004, 2006, 2013). *Analytical* intelligence, the kind that is measured by traditional intelligence tests, would help you solve a physics problem; *creative* intelligence is what you would use to compose music; *practical* intelligence would help you to figure out what to do if you were stranded on a lonely road during a blizzard. Along with his colleagues, Sternberg developed tests designed to measure all three (the *Sternberg Triarchic Abilities Test*, or *STAT*; Sternberg & Kaufman, 1998). A key theme in Sternberg's theory is that intelligence should be understood as something that makes a person successful in life generally, not just in academic settings, and that intelligence tests should measure the factors leading to success (Sternberg, 2011, 2016).

Some people whose intelligence test scores are only average, or even

below average, may display exceptional ability in certain specific areas, such as music or memory (Miller, 1999). Such cases are part of the evidence cited by Howard Gardner in support of a different multiple intelligences theory. According to Gardner (1993, 2002), there are at least eight intelligences or frames of mind: verbal, mathematical, spatial, bodily–kinesthetic, musical, intrapersonal, interpersonal, and naturalistic. He has recently proposed others, such as moral intelligence. Gardner says that traditional intelligence tests measure only the first three of these intelligences, the ones that are most valued in school. His theory has drawn considerable interest, especially in the field of education, and other researchers have proposed additional specific intelligences, including emotional intelligence (Mayer et al., 2011), social intelligence (Kihlstrom & Cantor, 2011), and even mating intelligence (Geher & Kaufman, 2011).

Gardner's model has been enormously influential in the field of education, but it is also controversial, partly because he has yet to develop standardized methods for assessing many of his multiple intelligences. As a result, Gardner's assertion that these intelligences are independent of *g* has yet to be established scientifically (Lubinski & Benbow, 1995).

Hierarchical and Factor-Analytic Models. After decades of research using statistical techniques known as *factor analysis*—most psychologists today have come to agree on a third psychometric view of intelligence that combines aspects of the other two. They recognize, first, that the positive correlation among various tests of cognitive ability reflects the factor known as *g* (e.g., Frey & Detterman, 2004). But they also realize that the *g* factor can be measured by many different groups of cognitive tests, even if the tests in each group are entirely different (Johnson et al., 2004). Their conclusion is that the brain probably does not contain a single, unified "thing"

corresponding to what people call intelligence. Instead, cognitive abilities appear to be organized in a *hierarchy*, or pyramid, of "layers." At the bottom of this hierarchy are as many as 50 or 60 narrow and specific skills that can be grouped into seven or eight more general ability factors, all of which combine at the top of the hierarchy into *g*, the broadest and most general of all (Carroll, 1993; Gustafsson & Undheim, 1996; Lubinski, 2004; see Figure 5.2). Understanding *g* and how it arises is a major goal of psychological research (Colom, Jung, & Haier, 2006; Garlick, 2002; van der Maas et al., 2006).

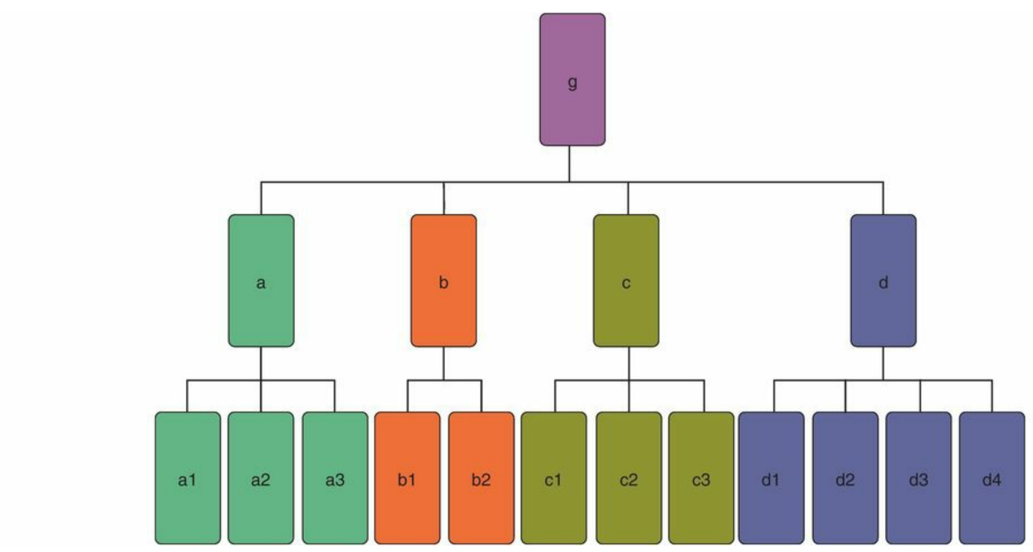

Figure 5.2 A Hierarchical Model of Intelligence
In this simplified example, specific abilities such as vocabulary knowledge or visual pattern recognition appear at the bottom of a hierarchy. These specific abilities are correlated because they share some common factor, such as a good memory, verbal knowledge, or rapid processing of information. These common factors appear at the middle level of the hierarchy. These middle-level factors are themselves correlated to some degree, and that correlation is represented at the top of the hierarchy by *g*, a single factor that includes them all.

The details of hierarchical models of intelligence continue to evolve in response to the results of additional factor-analytic studies (Dombrowski, 2013; Urbina, 2011). In the next sections, where we describe the most widely used tests of intelligence, it should be easy for you to spot the influence of hierarchical models in the general and specific cognitive abilities the tests are designed to measure.

The Binet Scales

The French scientist Alfred Binet was not the first person to develop a measure of intelligence, but as we mention in Chapter 2, his original test and the revisions based on it have been among the most influential means of assessing the mental ability of children. The earliest (1905) form of Binet's test—called the *Binet–Simon scale* in recognition of the contributions of his colleague Théodore Simon—consisted of 30 questions and tasks, including things like unwrapping a piece of candy, following a moving object with the eyes, comparing objects of differing weights, repeating numbers or sentences from memory, and recognizing familiar objects. A child's score on this test was simply the number of items passed.

Alfred Binet (1857–1911)

The tasks used by Alfred Binet and Théodore Simon provided the model for today's intelligence tests. Taking an analytic approach to test construction, they assumed that intelligence depends on reasoning, thinking, and problem-solving, so they chose tasks that measured children's ability to do these things (Binet & Simon, 1905).

(Source: Photo 12/Universal Images Group/Getty Images.)

Beginning with a 1908 revision, the tasks in Binet's test were *age graded,* meaning that they were arranged so that more difficult items would normally be passed by older children. For example, a "six-year-old item" was one that a large majority of six-year-olds could answer correctly but that most five-year-olds could not. The test was designed to measure a child's "mental level," later called *mental age*, by determining the age level of the most advanced items that the child could consistently answer correctly. Children whose mental age equaled their actual age, or chronological age, were considered to be of "regular"—that is, average—intelligence (Schultz & Schultz, 2000).

The 1908 Binet–Simon scale was translated and brought to the United States by Henry Goddard, who used it in his research with intellectually disabled children. Then, in 1916, Stanford University psychologist Lewis Terman published a revised version known as the Stanford–Binet Intelligence Scale (Terman, 1916). It included items for adults as well as children, and used an idea suggested by German psychologist William Stern to describe the relationship between mental and chronological age: *Stanford–Binet* results were expressed not simply as a mental age score, but as an *intelligence quotient* (or IQ) which is calculated by dividing mental age (MA) by

chronological age (CA) and multiplying by 100. So a six-year-old whose mental age is eight on the Stanford–Binet would have an IQ of 133 (8/6 × 100). When mental age and chronological age are the same, the IQ would be 100, a score that to this day is considered to represent "average" intelligence.

The most recent version of the Stanford–Binet, the *SB5*, was completed in 2003. As happens with all major test revisions, the SB5 went through a pilot-testing phase before being published. Norms for the revised test were based on a standardization sample of 4,800 people who were representative of the U.S. population in terms of age, sex, race/ethnicity, geographical region, and socioeconomic level. By keeping track of these variables during pilot-testing, the test developers could determine whether any items were answered differently, on average, by people from different demographic categories. Of the nearly 1000 items evaluated during this pilot-testing phase, only 293 were selected for the SB5 (Roid, 2003); here are just a few of them:

Vocabulary: Define words such as train, wrench, letter, error, and encourage.

Memory for sentences: Correctly recall sentences that were presented.

Object Series/matrices: Choose the sequence of objects or pictures that should come next to continue an existing pattern.

Absurdities: Identify the mistakes or "silly" aspects of pictures in which, for example, a man is shown using the wrong end of a rake or a girl is shown putting a piece of clothing on incorrectly.

Quantitative reasoning: Determine which numbers come next in a series of numbers such as the following: 32, 26, 20, 14, ____, ____.

Verbal relations: Indicate how three objects or words are alike but different from a fourth. For example, how are dog, cat, and horse alike but different

from boy.

Block span: Separate blocks into rows coded with yellow and red stripes.

The SB5 is based on a hierarchical model of intelligence (see Figure 5.2). Examiners can calculate a Full-Scale IQ score (a measure of *g*) based on all the test's items, but they can also report scores on ten groups of items called *subtests* (Roid, 2003). Half the subtests require *verbal* (i.e., language) skills; the other half are *nonverbal* subtests that do not depend heavily on those skills. The SB5 subtests are designed to measure five abilities that factor analysis research suggests are located at the middle level of the intelligence hierarchy. These abilities include *fluid reasoning* (e.g., completing verbal analogies, such as "hot is to cold as ____ is to low"), *knowledge* (e.g., defining words, detecting errors in pictures), *quantitative reasoning* (e.g., solving math problems), *visual-spatial processing* (e.g., assembling a puzzle), and *working memory* (e.g., repeating a sentence). Each of the five mid-level abilities is measured by one verbal and one nonverbal subtest, so in addition to reporting a Full-Scale IQ, the examiner can calculate a score for each of the five abilities, a total score on all the verbal tests (verbal IQ), and a total score on all the nonverbal tests (nonverbal IQ).

Research on the reliability of the fifth edition of the Stanford–Binet suggests that it has very high internal consistency, generally above 0.90. The test–retest reliability for the Full-Scale IQ was in the 0.93 to 0.95 range; for factor scores, the median was 0.88. A third measure of reliability, interscorer agreement, yielded a median correlation of 0.90 (Roid, 2003). These figures suggest high levels of reliability.

What about validity? As we explain in Chapter 3, one way to judge a test is to measure its criterion validity. This is done by comparing the test's

results with those obtained from other well-established measures of the same construct, in this case intelligence. It turns out that Full-Scale IQ scores on the SB5 are indeed similar to those obtained from other intelligence tests (correlations are in the range of 0.78 to 0.84). The test's validity is further indicated by the fact that groups of gifted, intellectually disabled, and learning-disordered children earn differing average scores on the test (Roid, 2003).

Its high reliability, and good validity for routine IQ testing, diagnosing intellectual disabilities, and predicting and explaining academic achievement (Decker et al., 2011; Walsh & Betz, 2001), explain why the Stanford–Binet remains one of the most widely used of all individually administered intelligence tests.

The Wechsler Scales

About 20 years after the Stanford–Binet appeared, David Wechsler, the chief psychologist at New York's Bellevue Psychiatric Hospital, began developing an intelligence test specifically for adults. The result of his efforts, the *Wechsler–Bellevue (W–B) Intelligence Scale*, was published in 1939. This test differed in several ways from the original Stanford–Binet, even though some W–B tasks were borrowed or adapted from it. First, the W–B was designed for testing people over the age of 17. Second, it contained verbal and nonverbal (performance) subtests. Third, the W–B was scored using a *point scale* in which the client received credit for each correct answer. Scoring the test this way meant that the resulting "IQ" was not really a quotient because it didn't express the relationship between mental age and chronological age. This change was needed because, unlike chronological age, mental age tends not to change much in adulthood. Sticking to the old MA/CA quotient would have created the impression that just about everyone becomes less and less intelligent as they get older! Instead, W–B scores were determined by comparing the points a client earned to those earned by people of the same age in the standardization sample. This scoring method eventually became the standard one for most intelligence tests today.

Wechsler also developed tests for children: the *Wechsler Intelligence Scale for Children* (WISC, often referred to as "the wisk") and the *Wechsler Preschool and Primary Scale of Intelligence* (WPPSI, or "the whipsee"). Each of the Wechsler scales has gone through several revisions and like the SB5, are among the most frequently used tests of intelligence.

The Wechsler Adult Intelligence Scale (WAIS). In 1955, Wechsler published a revised version of the W–B, called the *Wechsler Adult Intelligence Scale*, or WAIS (pronounced "wayz"). It soon became the most popular adult intelligence test in the United States. The WAIS was revised again in 1981 (WAIS-II), in 1997 (WAIS-III), and 2008 (WAIS-IV; Wechsler, 2008a). As with previous versions of the test, items on the WAIS-IV are presented in order of increasing difficulty within subtests. The test administrator stops each subtest after a predetermined number of item failures and then begins the next subtest. When the test is completed, the examiner can compute a Full-Scale IQ by converting the client's point totals to a standardized IQ score with a mean of 100 and standard deviation of 15. Table 5.1 shows some examples of the types of items included in the WAIS-IV (we can't display actual items, because the test is copyrighted).

Table 5.1 Items of the Type Included in Some of the Wechsler Adult Intelligence Scale (WAIS-IV) Subtests

Subtest	Simulated Items
Information	Where does lumber come from? What did Shakespeare do? What is the capital of France? What is the Malleus Malleficarum?
Comprehension	What should you do with a wallet found in the street? Why do imported cars cost more than domestic cars? What does "the squeaky wheel gets the grease" mean?
Arithmetic	If you have four apples and give two away, how many do you have left? If four people can finish a job in 6 days, how many

	people would it take to do the job in 2 days?
Similarities	Identify what similar pairs, like hammer–screwdriver, portrait–short story, dog–flower, have in common.
Digit Symbol/Coding	Copy designs that are associated with different numbers as quickly as possible.
Digit Span	Repeat in forward and reverse order two- to nine-digit numbers.
Vocabulary	Define chair, dime, lunch, paragraph, valley, asylum, modal, cutaneous.
Picture Completion	Find missing objects in increasingly complex pictures.
Block Design	Arrange blocks to match increasingly complex standard patterns.
Picture Arrangement	Place increasing numbers of pictures in sequence to make increasingly complex stories.
Symbol Search	Visually scan and recognize a series of symbols.

The WAIS-IV contains 15 subtests, 5 of which are considered optional. Responses to the subsets can be combined to create four *index* scores: *Verbal Comprehension*; *Perceptual Reasoning*; *Working Memory*; and *Processing Speed*. For example, a client's Perceptual Reasoning index score is derived from subtest scores for Block Design, Matrix Reasoning, and Visual Puzzles (and optionally from the supplemental subtests of Figure Weights and Picture Completion). These index-level scores are comparable to the mid-level intelligence hierarchy factors shown in Figure 5.2. The four index scores can

be further combined to create a General Ability Index score (based on Verbal Comprehension and Perceptual Reasoning scores) or a Full-Scale IQ score (based on all four index scores).

The Wechsler Intelligence Scale for Children (WISC) and Wechsler Preschool and Primary Scale of Intelligence (WPPSI). Appearing in 1949, the WISC was originally designed for children from 5 to 15 years old. It had 12 subtests (6 verbal, 6 performance), of which only 10 were usually administered. The latest version, the WISC-V, covers ages 6 to 17 and includes seven standard and nine supplemental subtests that provide a Full-Scale IQ and five composite factor scores: Verbal Comprehension, Visual Spatial, Fluid Reasoning, Working Memory, and Processing Speed (Wechsler, 2014a, b). Figure 5.3 shows items similar to those on the test.

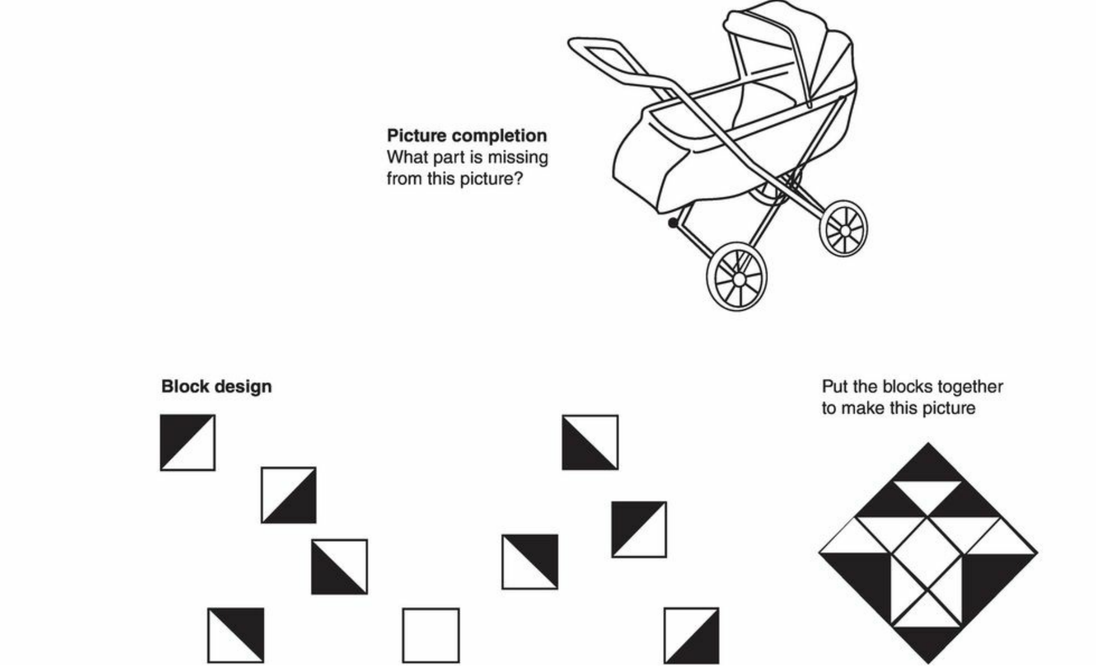

Figure 5.3 Items Similar to Those on the Wechsler Intelligence Scale for Children (WISC-V)

The WISC-V's subtests are grouped into five clusters. The *Visual Spatial* cluster includes tasks, such as the one shown at the bottom here, that involve assembling blocks. The *Fluid Reasoning* cluster includes tasks that require reasoning about pictures and solving math problems. The *Verbal Comprehension* cluster involves defining words, explaining the meaning of sentences, and identifying similarities between words. Tests in the *Working Memory* cluster require tasks such as recalling a series of numbers. The *Processing Speed* cluster tests children's ability to find symbols on a page and decipher simple coded messages.

The WPPSI, published in 1967, was designed for children aged 4 or younger (Wechsler, 1967). Its current fourth edition (WPPSI-IV) is meant for children in the 2.6 to 7.7 year age range (Wechsler, Raiford, & Coalson 2012).

The Wechsler scales have strong psychometric properties and norms. For instance, the WISC-V was normed on a sample of 2200 children ages 6 to 17. This sample matched the 2000 U.S. Census data in terms of the distribution of sex, race/ethnicity, parental education level, and geographic region. As with the revised SB5, inclusion of these and other variables allowed experts on cross-cultural research and intelligence testing to scour pilot-tested items for evidence of potential item bias. Individual items that were responded to differently by specific groups could be discarded in favor of items that did not show such group differences, as such differences can in some cases suggest bias.

The reliabilities of the Wechsler scales are also strong. For example, split-half reliabilities for Full-Scale IQ on the WAIS-IV and the WISC-V are 0.92 and 0.96, respectively, and interscorer agreement ranges from 0.98 to

0.99 (Wechsler, 2003, 2014a, b), suggesting that subjective or individually biased scoring—so often a concern with less-structured interviews, observations, or tests—is not a concern. In one study (Watkins & Smith, 2013), test–retest comparisons over a nearly 3-year period found that average subtest scores differed by no more than 1 point, and index scores differed by no more than 2 points. In terms of concurrent validity, the Wechsler tests correlate well with other established tests such as the Stanford–Binet. As for predictive validity, there are strong correlations with external criteria such as school grades, achievement test scores, and neuropsychological performance (Flanagan et al., 2011). Extensive discussion of standardization, reliability, and validity are provided in the technical manuals published for each test.

Clinical Interpretation of Intelligence Test Scores. Using intelligence tests such as the WAIS, WISC, or SB, clinicians can not only obtain a general measure of intellectual functioning (*g* or Full-Scale IQ), but also a multifaceted description of a person's cognitive strengths and weaknesses. The factor scores illustrated in the middle layer of Figure 5.2 represent potentially useful constructs for clinicians. Some researchers have suggested, for example, that children with attention-deficit hyperactivity disorder, learning disorders, or traumatic brain injury show relative weakness on measures of processing speed (Wechsler, 2003). Others have proposed diagnosing brain damage or impulsivity and other personality characteristics by using the variability or "scatter" of subtest scores (Groth-Marnat, 2003; Ryan, Paolo, & Smith, 1992; Wechsler, 2003). One study (Austin et al., 2011) described links between intellectual skills and personality, affect, risk of psychological disorders, and coping.

Still, clinicians should use caution when drawing inferences about such things based on the pattern of intelligence test subtest or factor scores.

Unequivocal diagnoses can rarely be made using the WAIS, SB, or WISC alone because the tests were not designed for neuropsychological assessment and the clinical usefulness of inter-score comparisons has not yet been empirically established (Hunsley & Mash, 2007). Furthermore, although intelligence test subtests themselves are typically reliable, small differences between them rarely are, so it can be difficult to reliably interpret the meaning of variability in scores across subtests (Watkins, 2003).

Other Intelligence Tests

The Binet and Wechsler tests are not the only individually administered intelligence tests available. Another popular one is the *Kaufman Assessment Battery for Children* (Kaufman & Kaufman, 1983, 2004a). Suitable for children 3 to 18 years of age, the test is now in its second edition, the K-ABC-II. Its standardization sample consisted of 3025 children who closely matched the U.S. Census on gender, race/ethnicity, parent education level, and geographical region, and the test has recently been re-normed on 700 additional children to make the sample even more representative of the population (Kaufman & Kaufman, 2018). The K-ABC-II is based on research and theory in cognitive psychology and neuropsychology (Mays, Kamphaus, & Reynolds, 2009). It defines intelligence as the ability to solve new problems (an ability sometimes referred to as *fluid intelligence*) and also as acquired knowledge of facts (which has been termed *crystallized intelligence*). As with the Binet and Wechsler tests, and consistent with the hierarchical model of intelligence, results of the Kaufman's subtests (18 total, 10 core) are grouped into mid-level composite factor scores, including simultaneous processing, sequential processing, planning, learning, and knowledge. In recognition of the growing complexity of intelligence as development occurs, the number of these composite scores used increases with age; three of them for 3 year-olds, four for children between the ages of 4 and 6, and five for children 7 and older. The K-ABC-II also results in two higher-level index scores: one for Mental Processing and one for the combination of Fluid-Crystallized Processing.

Internal consistency reliabilities are in the 0.90s, and test–retest coefficients are in the mid-0.80s to 0.90s. As for validity, the test shows high correlations with the WISC (McKown, 2011), and also correlates strongly with criteria such as school grades, achievement test scores, and neuropsychological performance (Braden, 1995; Kaufman & Kaufman, 2004a). A brief version called the *Kaufman Brief Intelligence Test-2* (K-BIT-2) is designed to yield estimates for crystallized and fluid intelligence in about 20 minutes (Kaufman & Kaufman, 2004b).

Taking an Intelligence Test

This child is taking the Woodcock–Johnson Tests of Cognitive Abilities (WJ-IV). The WJ can be used with people aged 2 to 90 to measure abilities that are more specific than those assessed by the Stanford–Binet and Wechsler tests. These abilities include fluid reasoning, verbal comprehension and knowledge, quantitative ability, visual-spatial thinking, short-term memory, retrieval from long-term memory, processing of auditory information, and mental processing speed.

(Source: © (2014) by the Riverside Assessments, LLC. Woodcock-Johnson (4th ed.), used with permission of the publisher. All rights

reserved.)

Several other intelligence tests in use today assess intelligence without emphasis on verbal or vocalization skills. *The Peabody Picture Vocabulary Test–Revised,* the *Leiter International Performance Scale,* and the *Raven's Progressive Matrices,* for example, allow clinicians to assess intellectual functioning in clients who are very young or have other characteristics that impair their ability at verbal tasks. These tests also provide a backup in cases in which the clinician suspects that a client's performance on a standard IQ test may have been hampered by anxiety, verbal deficits, cultural disadvantages, or other situational factors.

Aptitude and Achievement Tests

Intelligence tests can be viewed as general measures of both aptitude (the capacity to acquire knowledge or skill) and achievement (the knowledge or skill that a person has acquired). A number of other tests have been designed expressly to measure these more specific aspects of cognitive ability. *Aptitude tests* are usually designed to predict success in an occupation or an educational program. Along with overall cognitive ability, they measure the accumulated effects of many different educational and living experiences and attempt to forecast performance on the basis of these effects. *Achievement tests* measure proficiency at certain tasks; that is, they measure how much people know or how well they can perform in specific areas.

You are probably already familiar with the aptitude test known as the SAT (originally the *Scholastic Aptitude Test*), because it is widely used to predict high school students' potential for college-level work. It yields verbal and quantitative scores, and its latest revision now includes scores for an optional essay in the English section. The specific content of the SAT is revised continually. The questions change for each administration, and at any given time, some items are being piloted (and subsequently analyzed) for inclusion on a future test. Although the scoring scale stays the same, norms for the test are calculated on the basis of scores of the thousands of people who take each new version of the test.

Other popular aptitude or achievement tests include the *Woodcock–Johnson Test of Cognitive Abilities IV* and its cousin, the *Woodcock–Johnson Tests of Achievement IV* (Schrank et al., 2014). These tests measure general intellectual ability and specific academic achievement,

and yield both an overall ability score and a profile of scores on each specific ability. The *Wide Range Achievement Test* (WRAT5; Wilkinson & Robertson, 2017), the *Kaufman Test of Educational Achievement* (K-TEA-3; Kaufman & Kaufman, 2014) and the *Wechsler Individual Achievement Test* (WIAT-III; Wechsler, 2009) are other popular achievement tests. Clinicians and (especially) school psychologists use these tests to assess aptitude and achievement, to help identify learning disorders and to develop educational plans for children and adults (Bardos, Reva, & Leavitt, 2011).

There are numerous other tests measuring achievement and aptitude. The more specific the ability or aptitude being tested, the less likely you are to be familiar with it. If you have never heard of the *Seashore Measures of Musical Talents* or the *Crawford Small Parts Dexterity Test*, it is probably because you have never had occasion to be tested on these very specialized abilities. Such ability testing is more often done by human resources staff and educational, vocational, and guidance counselors than by clinical psychologists.

In Review Tests of Intellectual Functioning

Intelligence Tests		
Name	**Age Range**	**Results Obtained**
Stanford–Binet (SB5)	2–85+	Full-scale IQ; Verbal IQ; Nonverbal IQ; Composite scores for Fluid Reasoning, Crystallized Knowledge, Quantitative Knowledge, Visual-Spatial Processing, Working Memory.
Wechsler Adult Intelligence Scale (WAIS-IV)	16–90	Full-Scale IQ; Index scores for Verbal Comprehension, Perceptual Reasoning, Working Memory, and Processing Speed, plus a general ability index based on Perceptual Reasoning and Verbal Comprehension.
Wechsler Intelligence Scale for Children (WISC-V)	6–17	Full-Scale IQ; composite factor scores for Verbal Comprehension, Visual Spatial, Fluid Reasoning, Working Memory, and Processing Speed.
Kaufman Assessment Battery for Children (K-ABC-II)	3–18	Composite factor scores on Simultaneous Processing, Sequential Processing, Planning, Learning, and Academic Knowledge; also higher-level index

		scores on Mental Processing and Fluid-Crystallized Processing.
Aptitude and Achievement Tests		
SAT	No age limit, but meant for high school seniors	Scores of 200–800 on both language and math tests. Scores of 2–8 on optional essay test.
Woodcock–Johnson Tests of Achievement IV (WJ-IV)	2–90	Scores on 11 to 20 subtests which can be combined in various ways to result in factor scores on reading, written language, mathematics, and academic knowledge.

Test Yourself

1. Most psychologists see intelligence as composed of the ability to __________, to _______, and to________.

2. Today's IQ scores are the result of dividing mental age by chronological age and multiplying by 100. True ___ False___

3. Hierarchical models of intelligence see *g* as the combination of mid-level _________, which are themselves made up of more _________ abilities.

You can find the answers in the Answer Key at the end of the book.

Thinking Scientifically Are Intelligence Tests Biased Unfairly Against Certain Groups?

As you can see in Figure 5.4, the average IQ score of Asian Americans is typically the highest among various racial and ethnic groups, followed, in order, by European Americans, then Hispanic Americans and African Americans (Fagan, 2000; Herrnstein & Murray, 1994; Lynn, 2006). Similar patterns appear in the results of other cognitive ability and achievement tests (e.g., Koretz, Lynch, & Lynch, 2000; Sackett, Borneman & Connelly, 2008).

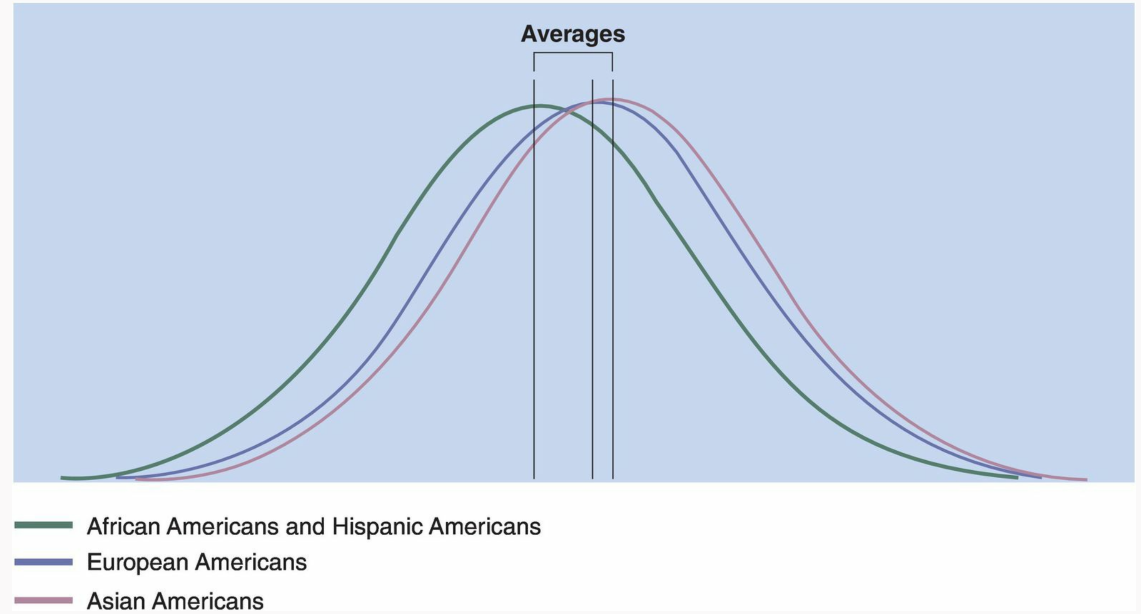

Figure 5.4 A Representation of Racial/Ethnic Group Differences in IQ Scores

The average IQ score of Asian Americans is four to six points higher than the average score of European Americans, who average 12 to 15 points higher than African Americans and Hispanic Americans. Notice, though, that there is much more variation within these groups than there is among their average scores.

(Source: Bernstein, D. A. (2019). *Essentials of psychology* (7th ed.) Belmont, CA: Wadsworth Cengage.)

What am I being asked to believe?

Why do these group differences occur? Some people claim that the lower average performance seen among Hispanic Americans and African Americans occurs because intelligence tests are unfairly biased against certain groups, resulting in IQ scores that do not accurately reflect cognitive ability, job potential, or other criteria that the tests are supposed to predict (Helms, 1997; Kwate, 2001; Neisser et al., 1996). They also contend that using intelligence tests to make decisions about people—such as assigning them to particular jobs or special classes—causes members of certain groups to be unjustly deprived of equal employment or educational opportunities.

Rachel Jackson's mother, Lena, certainly wondered about intelligence test bias after Rachel's 12-year-old brother, Jamal, whose wry sense of humor and "street smarts" had always impressed her, earned a surprisingly low score on the WISC-IV. Dr Leon had been asked to give him the test because Jamal was not doing well in any of his academic subjects, and was inattentive and somewhat disruptive in class. Lena was asked to come to school to discuss the possibility of putting Jamal in a special needs classroom. Did she have the wrong impression of her son all this time, or was there something wrong with the test?

What kind of evidence is available to support the claim?

Critics of intelligence tests point to evidence that the groups with the lowest average intelligence test scores are also the ones who were already at a competitive disadvantage because of factors operating before they ever took the test. These factors include, for example,

exposure to discrimination, lower-quality education, poverty, stereotyped media portrayals, and the like (Domino & Domino, 2006). As a result, children from certain ethnic and socioeconomic groups may be less well-equipped or motivated than other children to perform well on standardized tests (Duckworth, et al., 2011; Fagan, 2000). They may also be less comfortable in the testing situation and less likely to trust adult testers (Steele, 1997; Steele & Aronson, 2000). So the differences in test scores may partly reflect motivational or emotional differences among various groups, not intellectual ones (e.g., Claro, Paunesku, & Dweck, 2016; Rimfeld et al., 2016). This could certainly have been true in Jamal's case, given the stressors of life in his conflict-filled home, the experience of discrimination related to his interracial background, and always being compared unfavorably to the academic and athletic achievements of his twin sister, Janelle.

But bias can also be built into the test itself if, for example, it includes concepts or vocabulary that are more familiar to clients from some cultural backgrounds than from others (Sternberg & Grigorenko, 2004). Many intelligence test items reflect the vocabulary and experiences of the dominant middle-class culture in the United States, so individuals who are less familiar with the knowledge and skills valued by that culture will not score as well as those who are more familiar with them.

Are there alternative ways to interpret the evidence, including those that my biases and preconceptions might have kept me from seeing?

Still, evidence for bias in intelligence test items is mainly anecdotal, and may be less compelling than it might seem at first. As we mentioned earlier, test designers establish their standardization samples so as to be representative of people from all demographic groups, and during the norming process, they analyze responses to each test item. If, because of unfamiliarity with an item's vocabulary or other content, one group responds incorrectly at least 20% more often than other groups that item is considered to be potentially biased and is eliminated from the final version of the test. These procedures have greatly reduced or eliminated culturally biased items from today's most widely used intelligence tests.

As for the social and educational factors that place some groups at a disadvantage, test developers recognize that intelligence tests do not provide pure measures of raw cognitive ability. They point out, though, that their tests do provide a fair assessment of how likely it is that a person will succeed in school or in certain jobs. When some people have had more opportunity than others to develop their abilities, the difference will be reflected in higher IQ scores. From this point of view, well-validated intelligence tests are fair measures of the degree to which people have developed the cognitive abilities selected as most important in a society that, unfortunately, contains some unfair elements. In other words, the tests may be accurately detecting knowledge and skills that are not represented equally in all groups. That doesn't mean that the tests discriminate unfairly among those groups (Sackett, Borneman, & Connelly, 2008). Instead, the tests may be accurately reflecting the unfairly different educational and intellectual opportunities afforded to different groups.

What additional evidence would help to evaluate the alternatives?

If the problem of test bias really is a reflection of differences among various groups' opportunities to develop their cognitive skills, it will be important to learn more about how to reduce those differences. Making cultures fairer by enhancing the skill development opportunities of traditionally disadvantaged groups should lead to smaller differences among groups on tests of cognitive ability (Martinez, 2000).

At the same time, alternative tests of cognitive ability must also be explored, particularly those that include assessment of problem-solving skills and other abilities not measured by most intelligence tests (e.g., Shaunessy, Karnes, & Cobb, 2004; Sternberg & Kaufman, 1998). For example, there is growing evidence that standard IQ tests do an inadequate job of assessing the ability to think rationally, a capacity that is essential in many domains of everyday life (Stanovich, 2009). If new tests show smaller between-group differences than traditional tests, but have equal or better ability to predict people's academic or occupational performance, many of the issues discussed in this section will have been resolved. So far, efforts in this direction have not been especially successful.

What conclusions are most reasonable given the kind of evidence available?

In short, at this stage, differences in the average intelligence test scores of various racial and ethnic groups appear more likely to be due to differences in cultural conditions than to unfair bias in the tests

themselves, though both probably contribute. The distinguished psychometrician Anne Anastasi summarized the situation this way:

> *Tests are designed to show what an individual can do at a given point in time. They cannot tell us why*… *Tests cannot compensate for cultural deprivation by eliminating its effect from their scores. On the contrary, tests should* reveal *such effects, so that appropriate remedial steps can be taken. To conceal the effects of cultural disadvantages by trying to devise tests that are insensitive to such effects is equivalent to breaking a thermometer because it registers a body temperature of 101°.*
>
> (Anastasi, 1988, p. 66).

To summarize, although Jamal's low score on the WISC-IV may not accurately reflect his underlying cognitive potential, the test did provide an accurate portrayal of his performance on the day he took it. The fact that his score may have been due in part to the suppressive effects of certain motivational and sociocultural factors doesn't condemn the test as biased. In fact, it was the test results—especially when viewed in light of the superior academic performance of Jamal's sister— that led Lena to discuss those factors with her psychologist, Dr. Leon, and eventually led the Jacksons to participate in family therapy.

Tests of Attitudes, Interests, Preferences, and Values

Section Preview Clinical psychologists often find it useful to assess their clients' attitudes, interests, preferences, and values. For example, before beginning to work with a distressed couple, the clinician may wish to get some idea about each partner's attitudes about marriage or other committed relationships. Similarly, it may be instructive for the clinician to know that the interests of a client who is in severe conflict about entering the medical profession are utterly unlike those of successful physicians. Finally, assessment of attitudes, interests, preferences, and values can encourage clients to engage in their own self-exploration with respect to career decisions.

We don't have room to describe all of the many tests available to measure attitudes, interests, preferences, and values, so we will offer just a brief summary. Among those commonly used to assess clients' preferences for various pursuits, occupations, academic subjects, and activities are the *Self-Directed Search* (SDS; Holland, 1994, 1996), the *Strong Interest Inventory* (SII) (Hansen & Campbell, 1985), the *Campbell Interest and Skill Survey* (CISS; Cambell, 2008), and the *Kuder Occupational Interest Survey* (KOIS; Zytowski, 2007).

Tests such as these are widely used by school counselors to help students select college majors and possible occupations. Most of them yield an interest profile that can be compared with composite profiles gathered from members of occupational groups such as biologists, engineers, army

officers, carpenters, police officers, ministers, accountants, salespeople, lawyers, and the like (see Figure 5.5). Originally designed as paper-and-pencil tests, most of the highest quality interest and preference tests are now available from their publishers online. For a fee, anyone can take these tests and immediately receive a detailed report. Other tests are available at no cost, but remember that you get what you pay for; the reliability and validity of free tests, in general, is suspect.

YOUR HIGHEST THEMES	YOUR THEME CODE
Social, Artistic	SA

THEME	CODE	STANDARD SCORE AND INTEREST LEVEL	STD SCORE
Social	S	HIGH	62
Artistic	A	MODERATE	45
Enterprising	E	LITTLE	41
Conventional	C	LITTLE	40
Investigative	I	VERY LITTLE	34
Realistic	R	VERY LITTLE	32

Figure 5.5 A Sample Report from the Strong Vocational Interest Inventory The Strong Interest Inventory groups people's vocational interests into six themes: Social, Artistic, Enterprising, Conventional, Investigative, and Realistic. The results are presented both as a profile showing the relative strength of these themes, and a table showing the interests, jobs, skills, and values most commonly associated with each theme. Similar tests are under development for use in organizational psychology research (e.g., Su et al., 2018).

(Source: www.psychometrics.com/assessments/strong-interest-inventory-profile-report/)

THEME DESCRIPTIONS

THEME	CODE	INTERESTS	WORK ACTIVITIES	POTENTIAL SKILLS

Social	S	People, teamwork, helping, community service	Teaching, caring for people, counselling, training employees	People skills, verbal ability, listening, showing understanding
Artistic	A	Self-expression, art appreciation, communication, culture	Composing music, performing, writing, creating visual art	Creativity, musical ability, artistic expression
Enterprising	E	Business, politics, leadership, entrepreneurship	Selling, managing, persuading, marketing	Verbal ability, ability to motivate and direct others
Conventional	C	Organization, date management, accounting, investing, information systems	Setting up procedures, and systems, organizing, keeping records, developing computer applications	Ability to work with numbers, data analysis, finances, attention to detail
Investigative	I	Science, medicine, mathematics, research	Performing lab work, solving abstract problems,	Mathematical ability, researching, writing, analyzing

			conducting research	
Realistic	R	Machines, computer networks, athletics, working outdoors	Operating equipment, using tools, building, repairing, providing security	Mechanical ingenuity and dexterity, physical coordination

Instruments such as the *Study of Values* (SoV) (Allport, Vernon, & Lindzey, 1970; Kopelman, Rovenpor, & Guan, 2003) and the *Rokeach Value Survey* (RVS) are designed to measure values or generalized life orientations. The developer of the RVS suggested that values are different from attitudes or interests in that values are fewer in number and more central to a person's belief system and psychological functioning (Rokeach, 2000). To measure values, the latest edition of the SoV asks the client to answer 45 two- or four-option multiple-choice questions about topics such as how the client likes to spend time or what kinds of human activities seem most important. The test results are organized to show the relative strength of six basic interests: theoretical ("intellectual"), economic, aesthetic, social, political, and religious. In the RVS, people are asked to rank-order a set of 18 terminal values (such as health, social recognition, a comfortable life, a world at peace) and a set of 18 instrumental values (e.g., being broad-minded, intellectual, obedient, courageous).

The reliability and validity of interest and values tests are acceptable, but not as high as those of the intelligence measures we described earlier. The difference may stem partly from the structure of attitude, interest, preference,

and values tests. Many of them require clients to make rankings or forced choices, which means that when certain items are ranked high, others are necessarily ranked low. Also, test takers often don’t have as much confidence in rankings as they do when responding to more focused items; a preference or value that was ranked third on one testing occasion might be ranked fifth or sixth a year later. In addition, the structure of occupational or vocational interests can differ among various segments of the population, meaning that the results of interest tests may be more valid for, say, males versus females (Kantamneni & Fouad, 2010). Despite their psychometric limitations, these tests are widely used, perhaps because of their content validity and their ability to stimulate personal and career exploration.

Tests of Psychopathology and Personality

Section Preview In this section, you will learn about psychological tests that were designed specifically to assess human characteristics beyond intelligence, attitudes, interests, preferences, and values. These tests are meant to provide personality-related information that helps clinical psychologists to describe people as individuals and compare them with others. Some of these tests are used for conducting research on the general characteristics of personality, others for diagnosing psychological disorders, and some for both purposes. We will first describe objective, or structured, tests in which clients make choices, ratings, or true–false responses to relatively simple, largely unambiguous items. Then we will consider projective, or unstructured, tests, which ask clients to draw pictures or say what they see in ambiguous visual images. The section ends with a discussion of the strengths and weaknesses of both kinds of tests.

Personality is generally defined as the relatively stable pattern of behavioral and psychological characteristics by which a person can be compared with others (Schultz & Schultz, 2017). Some clinicians see personality as an organized collection of traits, whereas others see it in terms of dynamic relationships among intrapsychic forces, recurring patterns of learned behavior, or ways in which people perceive the world. These different views reflect psychodynamic, behavioral, humanistic, and other theories about personality and have led, in turn, to a wide range of methods for measuring it. In fact, there are more psychological tests devoted to measuring personality than to any other clinical target, and researchers

continue to explore it by burrowing down to identify ever more specific subdimensions that can provide higher levels of resolution—much as more powerful microscopes can offer an increasingly detailed understanding of otherwise invisible worlds (McCrae & Mõttus, 2019).

Personality
The pattern of behavioral and psychological characteristics by which a person can be compared and contrasted with others.

There are two major types of tests for measuring the dimensions and disordered aspects of personality: objective and projective. *Objective* (or *structured*) *personality tests* present relatively clear, specific stimuli such as questions ("Have you ever wanted to run away from home?") or statements ("I am never depressed") to which the client responds with direct answers, choices, or ratings. Most objective personality tests are of the paper-and-pencil variety (although they can now be administered online) and can be scored arithmetically, usually by computers, much like the multiple-choice or true–false tests used in many college classrooms. Some objective tests focus on one aspect of personality, such as anxiety, dependency, or ego strength (akin to resilience or resourcefulness), while others provide a fairly comprehensive overview of many personality dimensions.

Projective (or *unstructured*) *personality tests* ask clients to respond to ambiguous stimuli (such as inkblots, drawings, or incomplete sentences) by describing and telling stories about what they see, or by completing

sentences. Sometimes the client is given a task, such as to draw a person or an inanimate object. The clinician scores the client's responses and interprets their meaning, usually in terms of the conscious and unconscious aspects of personality they seem to reveal.

Objective Tests of Psychopathology

The first objective, structured personality test developed by a psychologist was the *Psychoneurotic Inventory*, which, as we mention in Chapter 2, was renamed as the *Personal Data Sheet* when it was used during World War I to identify army recruits who might have psychological problems (Woodworth, 1920). It asked for yes-or-no answers to questions such as "Did you have a happy childhood?" "Does it make you uneasy to cross a bridge?" The inventory was developed using an early version of the empirical approach to test construction; its items were initially selected because they reflected problems and symptoms reported by at least twice as many previously diagnosed "neurotics" as by "normals" (such labels are no longer used). Items were then dropped if more than 25% of a new sample of "normal" people answered them in an unfavorable manner.

The Minnesota Multiphasic Personality Inventory. Among the hundreds of objective personality measures that have appeared since the Personal Data Sheet, the most influential is the *Minnesota Multiphasic Personality Inventory (MMPI).* In fact, it is the world's most widely used instrument for the assessment of clinical symptoms and personality in adults (Ben-Porath & Tellegen, 2008; Butcher et al., 2015; Van Der Heijden, Egger, & Derksen, 2010). This test was developed during the late 1930s at the University of Minnesota by Starke Hathaway (a psychologist) and John C. McKinley (a neurologist) as an aid to diagnosing psychological disorders in psychiatric patients at the University's Hospital. Using a purely empirical approach, Hathaway and McKinley took about 1000 items from older personality tests and other sources and converted them into statements to

which clients could respond “true,” “false,” or “cannot say.” More than half of these items were then presented to thousands of people, some of whom had already been diagnosed with various psychiatric disorders.

Certain response patterns appeared. When compared with people who had not been diagnosed with any disorder, members of various diagnostic groups showed statistically distinct patterns of responses. For example, depressed people tended to respond in the same way to one particular set of items, whereas those who had been diagnosed with schizophrenia tended to respond in the same way to a different set of items. Analyses of these patterns identified eight sets of items, called *clinical scales*, that were associated with certain disorders, and that differentiated people who displayed disorders from those who did not. The original MMPI also included three *validity scales* (along with a fourth validity indicator that referred to the number of items the respondent left blank). The validity scales are groups of items designed to identify people who are trying to exaggerate or hide their problems, who are misunderstanding the test items, or are being uncooperative. For example, someone who responds “true” to items such as “I never get angry” might not be giving honest answers to the rest of the test. There were 567 items in the final version of the MMPI.

After being widely used for many years—and translated into 25 languages, including American Sign Language (Brauer, 1993)—the original MMPI eventually became outdated (Dahlstrom, 1992). Accordingly, an extensively revised version, called the MMPI-2, was published in 1989. The revision effort focused on gathering new normative data from a random sample of 2600 non-disordered adults and adolescents who were more representative of the U.S. population, as well as from several clinical populations. Also, 154 new items were evaluated for possible inclusion in the

test and outmoded items, such as “I like to play ‘drop the handkerchief’” (a once-popular children’s game), were dropped. An alternative, briefer, version, the MMPI-2-RF (for “restructured form”) appeared in 2008 and contains 388 items, nine clinical scales, and 11 validity scales (Tellegen & Ben-Porath, 2008/2011). A special version for adolescents, the MMPI-A-RF was published in 2016. It consists of 241 true–false items which produce scores on 48 scales, among which are 14 restructured clinical scales, 3 higher-order scales, 6 validity scales, and 25 specific problem scales. There are also 14 “critical items” designed to detect problems of serious and immediate clinical concern, including 7 focused on depressive and suicidal thoughts (Archer et al., 2016).

It takes about 35 to 50 minutes to complete the MMPI-2-RF, depending on respondents’ reading skills (the items are written at the fifth-grade level), and whether they are using the (usually slower) paper-and-pencil format or working with a computerized or online version. To interpret the meaning of MMPI-2-RF results, a person’s scores on the nine clinical scales are plotted as a profile (see Figure 5.6). After corrections based on validity scale scores, this profile is then compared with the profiles of people who are known to have certain personality characteristics or problems. The comparison can be done by computer programs that contain huge normative databases, or by individual clinicians using scoring manuals and their own experience with previous clients. The assumption underlying this comparison process is that people’s personality characteristics and psychological problems will be most like those of people in the standardization sample whose profiles most closely match their own. So although a high score on a particular clinical scale, such as Demoralization, might suggest a problem with depression, interpreting the MMPI-2-RF usually focuses on the overall pattern in the clinical scale scores

—particularly on the combination of two or three scales on which a person's scores may be unusually high.

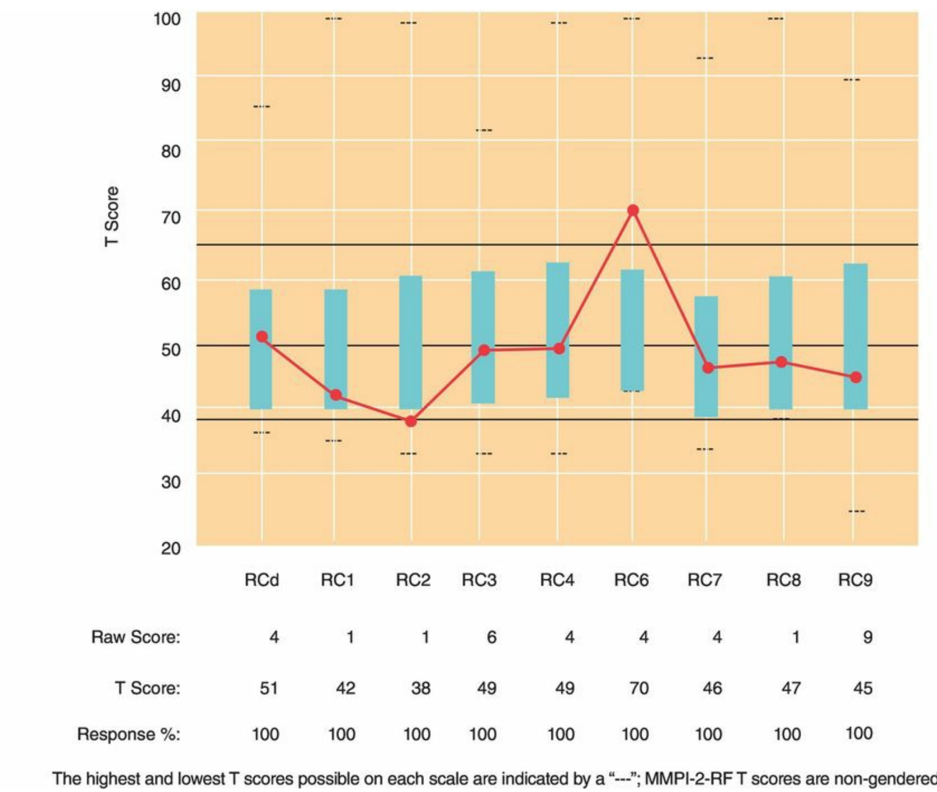

Figure 5.6 The MMPI-2-RF Restructured Clinical Scales and Sample Profile

A score of 50 on the clinical scales of the MMPI-2-RF is average. Scores at or above 65 mean that the person's responses on that scale are more extreme than at least 95% of the non-disordered population. The red line on this chart represents the MMPI-2-RF profile of Rachel's Jackson's father, James, who took the test when he was in college. It is characteristic of a person who is about average in most ways, but who believes that other people are against him, are "out to get him," or are a threat to him.

The nine clinical scales abbreviated in the figure are as follows (this number of scales differs slightly from the MMPI and MMPI-2). (Source:

Bernstein, D. A. (2019). *Essentials of psychology* (7th ed.). Belmont, CA: Wadsworth Cengage.)

RCd: Demoralization—General unhappiness and dissatisfaction

RC1: Somatic Complaints—Diffuse physical health complaints

RC2: Low Positive Emotions—Lack of positive emotional responsiveness

RC3: Cynicism—Beliefs that express distrust and a generally low opinion of others

RC4: Antisocial Behavior—Rule breaking and irresponsible behavior

RC6: Ideas of Persecution—Beliefs that others pose a threat to oneself

RC7: Dysfunctional Negative Emotions—Maladaptive anxiety, anger, irritability

RC8: Aberrant Experiences—Unusual perceptions or thoughts

RC9: Hypomanic Activation—Overactivation, aggression, impulsivity, and grandiosity

The MMPI clinical scales appear to have adequate levels of test–retest reliability as well as reasonable validity for most of their intended clinical purposes (e.g., Butcher, 2013; Tellegen et al., 2003), but even the latest editions of the test are far from perfect measurement tools. Despite what Hathaway and McKinley had hoped, a particular pattern of MMPI scale scores does not guarantee the presence of a particular disorder. As a consequence, the test should rarely if ever be used by itself to make a psychiatric diagnosis. The validity of MMPI interpretations may be particularly suspect when—because of cultural factors—the perceptions, values, and experiences of the test taker differ significantly from those of the

test developers and the people with whom the respondent's results are compared. So although an MMPI profile might look like that of someone with a mental disorder, the profile might actually reflect the culture-specific way the person interpreted the test items, not a psychological problem (Butcher, 2004). Even though the MMPI-2-RF uses comparison norms that represent a more culturally diverse population than did those of the original MMPI (Ben-Porath & Archer, 2014), clinicians must still be cautious when interpreting the profiles of people who identify with minority subcultures (Butcher, 2004; Cheung, van de Vijver, & Leong, 2011; Church, 2010; Pace et al., 2006).

The Personality Assessment Inventory. One promising alternative to the MMPI **f**or assessing psychopathology is the *Personality Assessment Inventory* (PAI; Morey, 2007). The PAI consists of 344 statements, which clients rate on a 1 to 4 scale to reflect the degree to which they agree with each. Designed to assess a broad range of clinical symptoms, the test provides four validity scales (e.g., Inconsistency, Negative Impression) designed to detect problematic response styles such as malingering, 11 clinical scales (e.g., Somatic Complaints, Anxiety, Borderline Features), and numerous descriptive clinical subscales (e.g., Somatic Complaints-Conversion, Mania-Grandiosity, Antisocial Features-Stimulus Seeking). The test also provides supplemental indexes designed to be used in treatment planning (e.g., Suicide Potential Index, Defensiveness Index) (Morey, 2007). Since its introduction, this instrument has become quite popular in clinical and research settings, no doubt owing partly to the numerous studies supporting its reliability and validity for its intended purposes (Morey et al., 2011).

The Millon Clinical Multiaxial Inventory. Another alternative to the

MMPI is the fourth edition of the Millon Clinical Multiaxial Inventory (MCMI-IV). At 195 items, it is shorter than either the MMPI or the PAI. First published in 1982, the MCMI was revised in 1987, 1997, and most recently in 2015 (Millon, Grossman, & Millon, 2015). The test yields 30 scales, five of which are designed to assess the test's validity or to modify its clinical interpretation. There are 15 scales devoted to personality patterns/disorders (e.g., avoidant personality disorder, antisocial personality disorder) and the test is designed to link up with the diagnostic criteria used in the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*) and the World Health Organization's *International Classification of Diseases* (*ICD-11*). Interpretation of the MCMI-IV "requires considerable sophistication and knowledge related to psychopathology in general and personality disorders in particular" (Groth-Marnat, 2003, p. 323). As a result, its interrater reliability tends to be somewhat lower than that associated with the MMPI scales. Nevertheless, the test remains one of the more popular in the clinical arsenal; many clinicians find it useful for assessment and for treatment planning (Retzlaff, Dunn, & Harwood, 2011).

The Personality Inventory for the DSM-5 (PID-5). One of the first tests designed specifically to reflect the *DSM-5*, the Personality Inventory for the DSM-5 (PID-5) is a 220-item instrument developed by the DSM-5 Personality and Personality Disorders Workgroup (American Psychiatric Association, 2013). It was intended to assess personality disorders as defined in the then-new DSM-5. Preliminary analyses suggest reasonable convergent validity with measures such as the MMPI-2, but further analyses will be needed on this and all other measures designed to coincide with the DSM-5 (Al-Dajani, Gralnick, & Bagby, 2016; Anderson et al., 2013).

Tests Measuring Specific Aspects of Psychopathology. The tests we

have described so far were designed to provide general profiles of psychopathology, but there are also numerous tests that are aimed at assessing more specific aspects of disorder. One prominent example is the *Beck Depression Inventory,* now in its second edition, the *BDI-II* (Beck, Steer, & Brown, 1996). It contains only 21 items, so it takes only about 10 minutes, and there is a 13-item short form that can be completed even more quickly. Both forms ask clients to rate on a 0 to 3 scale the degree to which each item describes them. The test yields scores that are grouped from little or no depression (13 and below) to severe depression (29 and above). The factor structure of this test is reasonably clear, though some studies suggest that it measures one factor (a general expression of depression), whereas others have found two (cognitive and somatic expressions of depression) (Ward, 2006). The ease of administration and good psychometric properties of the BDI-II makes it appealing to clinicians, including those who are conducting research on depression (Groth-Marnat, 2009). Other prominent self-report tests for depression include the Hamilton Depression Symptom Questionnaire, and the Profile of Mood States (see Feliciano, Renn, & Arean, 2012).

There are also countless tests aimed at other forms of psychopathology. For example, to assess the intensity of a client's phobias, a clinician might select the *Fear Survey Schedule* (FSS). Its various versions present a list of 50 to 122 objects and situations that the client is to rate in terms of fearsomeness on 1 to 5 or 1 to 7 scales (e.g., Geer, 1965; Lawlis, 1971; Wolpe & Lang, 1969). Other instruments such as the Panic Disorder Severity Scale (Shear et al., 1997) are available to assess the symptoms of panic disorder. Lists and brief descriptions of disorder-specific tests are available in several publications (e.g., Antony & Barlow, 2010; Butcher, 2009; Harwood

et al., 2011a; Hersen & Beidel, 2012), as well as in the latest edition of the *Mental Measurements Yearbook* (Carlson, Geisinger, & Jonson, 2017).

Objective Tests of Personality

Clinical psychologists are usually interested in tests that provide information about psychological disorders, but they sometimes want a more general overview of a client's personality characteristics, either for research purposes or to get a better idea of a client's strengths and weaknesses.

The numerous objective tests designed to provide this kind of overview reflect particular theories and research evidence about the traits and dimensions that form the structure of human personality. The *Eysenck Personality Questionnaire* (Eysenck & Eysenck, 1975; Eysenck, Eysenck, & Barrett, 1985), for example, is based on factor-analytic research by British psychologist Hans Eysenck, showing that personality traits tend to cluster into three main dimensions: *Introversion–Extraversion*, *Neuroticism–Stability*, and *Psychoticism*. (The last dimension, incidentally, seems to measure a propensity toward recklessness and selfish risk-taking, not a tendency toward psychosis.) People taking the most recent version of the test, the EPQ-R earn a score on each of these dimensions, of which the first two are particularly important (see Figure 5.7). Another factor-analytically based test, the *Multidimensional Personality Questionnaire* (MPQ; Tellegen 1982), measures three similar but somewhat broader dimensions: *Positive Emotionality*, *Negative Emotionality*, and *Constraint*, the last of which is the reverse of Eysenck's Psychoticism dimension. There are still other, even broader, personality tests that are widely used by psychologists in clinical practice and especially in clinical research. Here, we consider just a few of the most prominent ones.

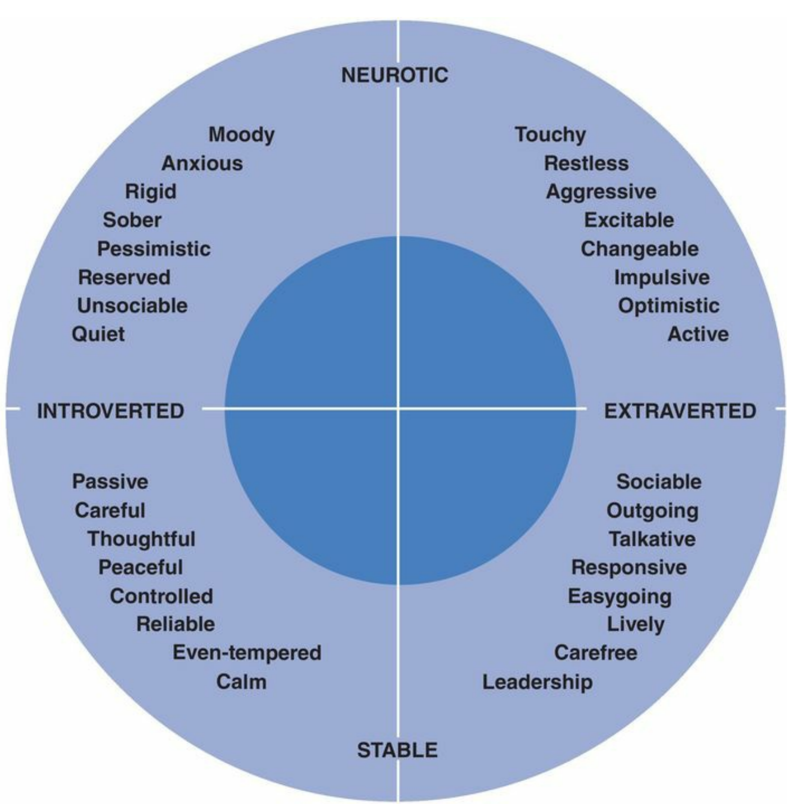

Figure 5.7 Two Main Personality Dimensions Measured by the EPQ

Try this According to Eysenck, varying degrees of neuroticism–stability and introversion–extraversion, combine to produce predictable trait patterns, as shown in the four sections created by crossing his two main personality dimensions. Take a minute to think about which section of the figure you think best describes your own personality. How about those of a friend or a relative? Did you find it any easier to place other people's personalities in a particular section than to place your own? If so, why do you think that might be?

(Source: Bernstein, D. A. (2019). *Essentials of Psychology* (7th ed.). Belmont, CA: Wadsworth Cengage.)

The NEO-Personality Inventory. One of the most popular personality research tools today is the NEO-PI, so named because it was originally designed using analytic methods as a measure of three broad personality

dimensions: *Neuroticism* (N), *Extraversion* (E), and *Openness* (O). It was later expanded to become the NEO-PI-R (for revised), which included two additional dimensions: Agreeableness (A) and Conscientiousness (C) (Costa & McCrae, 1980, 1985, 1992). The latest edition is called the NEO-PI-3 (McCrae, Harwood, & Kelly, 2011). You can remember the NEO's five broad dimensions of personality by remembering that their first letters can be arranged to spell OCEAN or CANOE.

Though developed as a comprehensive measure of normal adult personality dimensions, the Five-Factor (or "big five") model on which the NEO-PI is based has also been helpful in assessing psychological disorders, predicting progress in psychotherapy, and perhaps even in selecting optimal forms of treatment for some clients (Widiger & Presnall, 2013). These uses have been challenged by clinicians who are not convinced that instruments like the NEO-PI add clinically useful information beyond that provided by tests like the MMPI and its variants (Ben-Porath & Waller, 1992). Advocates, however, contend that although the NEO-PI-3 is not a stand-alone instrument in clinical settings, it can provide important supplemental information about clients' strengths as well as weaknesses, information that is useful in diagnosis, rapport-building, and treatment planning (McCrae et al., 2011). The test takes about 30 minutes to complete, and it has good test–retest reliability and good validity for its intended uses. It continues to be an extensively researched test whose clinical applications are still developing.

The California Psychological Inventory. Another prominent broad-range objective personality test is the *California Psychological Inventory (CPI)*. It was introduced in 1957 and revised in 1987 with updated content and reworded items (Gough, 1987). Like the NEO-PI-3, the CPI was developed specifically for assessing personality in the "normal" population.

Unlike the NEO-PI-3, however, the CPI was developed primarily using empirical methods. For example, its Dominance scale was constructed by comparing the item responses of individuals who had been rated by others as high versus low in social dominance. About half of the CPI's 462 true–false items come from the MMPI, but CPI items are grouped into 15 scales that are more diverse and positively oriented, including sociability, self-assurance, achievement potential, responsibility, self-control, and the like. There are also three validity scales that serve essentially the same purpose as those on the MMPI. The CPI's strengths include its relatively high reliability and its ability to predict delinquency, parole outcome, academic grades, and the likelihood of dropping out of high school (Anastasi & Urbina, 1997; Groth-Marnat, 2009). Its weaknesses include the fact that many of its scales overlap substantially with each other and therefore tend not to provide unique information (Nichols & Schnell, 1963).

Other Objective Personality Tests. There are numerous other general tests of personality. For example, Raymond B. Cattell used both psychological theory and factor-analytic research to identify 16 basic personality factors, and like Eysenck, created an instrument to measure them (Cattell, Eber, & Tatusoka, 1970; Cattell et al., 1993*;* Russell & Karol, 2002). Each of the 187 items on the latest edition of the *16 Personality Factors Questionnaire* (16PF5e) asks respondents to choose from among three options (for example, "I would prefer to visit: a museum, a national park, or an art gallery"). The results are converted into the person's score on each of the 16 factors, which include warmth, reasoning, emotional stability, dominance, liveliness, rule-consciousness, social boldness, sensitivity, vigilance, abstractedness, privateness, apprehension, openness to change, self-reliance, perfectionism, and tension.

The *Myers–Briggs Type Indicator* (MBTI) (Myers & Briggs, 1943) is an analytically derived test based on Carl Jung's psychoanalytic personality-type classification system (Jung, 1921/1971). Responses to the test's 126 forced-choice items are used to classify people into 16 "types" based on combinations of their scores on four scales: Extraversion/Introversion (E or I), Sensation/Intuition (S or N), Thinking/Feeling (T or F), and Judging/Perceiving (J or P). Proponents of the test claim that it provides information about the strength of each of these dimensions that is useful not only for "typing" people, but for predicting their behavioral tendencies and potential for success in certain jobs. These claims have led to the widespread use of the MBTI—especially in the business world. Unfortunately, the test's popularity is far greater than is justified by its questionable reliability and validity (Domino & Domino, 2006; Gardner & Martinko, 2016; Pittenger, 2005). In short, though you may hear a lot about this test, and may even be asked to take it when applying for a job, be aware that its psychometric quality is among the lowest of all objective personality tests.

Projective Personality Tests

The projective, or unstructured assessment of personality can be traced back to the 1400s, when Leonardo da Vinci is said to have selected his art pupils partly on the basis of the creativity they displayed while attempting to find shapes and patterns in ambiguous forms (Piotrowski, 1972). The projective tests in use by clinical psychologists today grew out of Freud's notion that people "project," or attribute to others, certain aspects of their own personality, especially the unacceptable ones. This *projective hypothesis* states that each individual's personality will determine, to a significant degree, how he or she interprets and responds to ambiguous, unstructured stimuli. Tests that encourage clients to display this tendency are called *projective methods* (Frank, 1939). Let's consider a few of the most prominent projective personality tests.

The Rorschach Inkblot Test. One of the most widely known, frequently used, and scientifically controversial projective personality measures is the *Rorschach Inkblot Test*, a set of 10 colored and black-and-white inkblots created by Swiss psychiatrist Hermann Rorschach between 1911 and 1921. When the test's manual (Rorschach, 1921) was published, European testing experts such as William Stern denounced it as "faulty, arbitrary, artificial, and incapable … of understanding human personality" (Reisman, 1976). Nevertheless, David Levy—an American psychiatrist from Columbia University who was studying in Switzerland in the early 1930s—brought a copy of the test home with him. He taught a psychology Ph.D. student named Samuel Beck how to use it, and in 1937, Beck published the first English language manual describing how to give and score the test

(Beck, 1937). By 1950, there were manuals for five different scoring systems in print (e.g., Klopfer & Kelley, 1937, 1942; Rapaport & Schafer, 1945; Weiner & Greene, 2008). These manuals helped make the Rorschach the most commonly used test among clinical psychologists from the 1930s through the 1960s. Decades ago, a prominent clinician noted that "it is hard to conceive of anyone in the field of clinical psychology reaching the postdoctoral level without being thoroughly well versed in the Rorschach" (Harrower, 1965, p. 398).

That is no longer the case. Whereas tests such as the Wechsler and the MMPI remain in wide use, the Rorschach's popularity has declined significantly, mainly because of empirical evidence unfavorable to its reliability and validity (Wood et al., 2010), and because it is not clear that the test provides much information over and above what is obtainable from less elaborate measures such as brief questionnaires (Garb, 1984).The test itself is simple. The client is shown 10 cards, one at a time. On each card is an inkblot similar to the one shown in Figure 5.8 and the client is asked to say what the blot could be. As the client responds to the cards, the clinician takes word-for-word notes, records how each card was held (e.g., upright, sideways), and often keeps track of response times and silences, notable emotional reactions, and other behaviors. After the last card is presented, the clinician conducts an *inquiry*, or systematic questioning, in which the client is asked to say what it was about each blot that prompted the responses given.

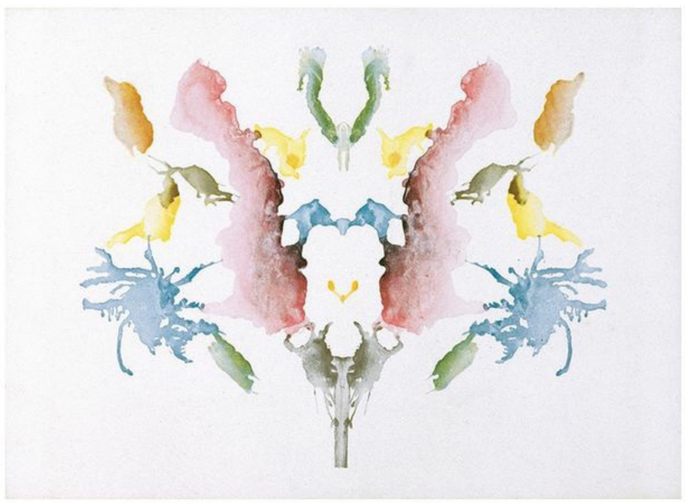

Figure 5.8 An Inkblot Similar to Those Used in the Rorschach

Try this People taking the Rorschach Inkblot Test are shown ten patterns similar to this one and asked to tell what the blot looks like and why. Under the standard administration method, respondents can give as many responses as they wish, but this flexibility can be problematic. The more responses they give, the higher the chances that they will say something deemed to be pathological (Lipgar, 1992). Jot down what you see in the blot, and then compare your responses with those of some friends.

(Source: Science & Society Picture Library/SSPL/Getty Images.)

The complete record of the client's responses, called a *protocol*, is then converted, or coded, into scores which are interpreted by the clinician as meaning certain things about the client's personality. Scoring procedures can be complex, but most systems code, at a minimum, the *location*, *determinants*, *content*, *popularity*, and *form quality* of the client's responses (see Table 5.2). Suppose, for example, that a client looked at the blot shown in Figure 5.8 and said, "It looks like a butterfly," and when asked about this response during the subsequent inquiry, said "I saw the whole blot as a butterfly because it is colorful and just sort of butterfly-shaped." According

to one of the Rorschach scoring systems, these responses would probably be coded as WFCF+AP, where W indicates that the whole blot was used (location); F means that the blot's form was the main determinant of the response; and CF means that chromatic color was involved. The + shows that the form that the client described corresponded well to the actual form of the blot; A means that there was animal content in the response; and P indicates that "butterfly" is a popular response to this particular card.

Table 5.2 Scoring Categories for the Rorschach Inkblot Technique

Scoring Category	Refers to
Location	The area of the blot to which the client responds: the whole blot, a common detail, an unusual detail, white space, or some combination of these are location responses.
Determinants	The characteristics of the blot that influenced a response; they include form, color, shading, and "movement." Although there is no movement in the blot itself, the respondent's perception of the blot as a moving object is scored in this category.
Content	What is perceived in the blot; it might include human figures, parts of human figures, animal figures, animal details, anatomical features, inanimate objects, art, clothing, clouds, blood, X-rays, sexual objects, and symbols.
Popularity	How often the client's responses have been made by previous respondents.
Form	The degree to which the content reported conforms to the

Quality	blot’s objective form.

The statements made about a client’s responses to the Rorschach depend, first, on how the clinician codes them and, second, on how the pattern of codes is interpreted. For a long time, response coding could differ depending on which of five competing scoring systems clinicians used, and how they chose to use it. This ambiguity led to considerable confusion and almost certainly reduced the test’s interrater reliability. It was not until the mid-1970s that John Exner, a psychologist at Long Island University proposed what he called a *Comprehensive System* for scoring and interpreting the Rorschach (Exner, 1974, 1993, 2003; Exner & Erdberg, 2005). His system was designed to improve interrater reliability by providing more specific guidelines for response coding. Exner also aimed to retain the Rorschach indices that had the highest validity for various clinical purposes. Clinicians using the Comprehensive System record the overall number of client responses (called *productivity*), put them into categories, record the frequency of responses in certain categories, and look for recurring patterns of responses across cards. For example, because most people tend to use form more often than color in determining their responses, a high proportion of color-dominated determinants is often interpreted as evidence of weak emotional control, although there is not much research support for this interpretation.

Exner’s Comprehensive System quickly became the dominant system for administering and scoring the test. More recently, the Rorschach Research Council—a group founded by Exner to further improve the Comprehensive System—tried to promote that goal by creating the *Rorschach Performance Assessment System* (*RPAS*; Meyer et al., 2010; Meyer & Eblin, 2012). In

contrast to standard Rorschach administration procedure, RPAS administration requires all clients to make a standard number of responses per card. In addition, because the RPAS focuses on Rorschach indices with adequate validity, it contains far fewer scores than does the Comprehensive System. Some see the RPAS as an extension of the Comprehensive System, but there are enough differences (including new scoring categories such as Complexity, Space Integration, and Space Reversal) that it is considered by many to be the next new scoring system (Krishnamurthy et al., 2011).

The Thematic Apperception Test. Like the Rorschach, the *Thematic Apperception Test* (TAT) consists of a set of cards, but there are 31 of them, 30 of which show drawings of people, objects, and landscapes; one is blank. The TAT was designed in 1935 by Christiana D. Morgan and Henry Murray at the Harvard Psychological Clinic (Murray, 1938, 1943). It was based on the projective hypothesis and on the assumption that, in telling a story, the client's needs and conflicts will be reflected in at least one of the story's characters (Lindzey, 1952). In most cases, the clinician shows the client a subset of 10 or fewer cards, chosen on the basis of assessment goals and on the client's age and sex. (Alternative card sets depicting African Americans, Asians, and other racial/ethnic groups are available to make the test more relevant to clients of differing backgrounds.) The clinician shows each drawing and asks the client to make up a story about it, including what led up to the scene, what is happening now, what is going to happen, and what the main characters in the card are thinking and feeling. For the blank card, the respondent is asked to imagine a drawing, describe it, and then construct a story about it.

Scoring and interpretation of the TAT can focus on both the *content* and the *structure* of the client's stories. Content refers to what clients describe:

the people, the feelings, the events, the outcomes. Structure refers to how clients tell their stories: their logic, organization, and use of language, the appearance of speech dysfluencies, the misunderstanding of instructions or stimuli in the drawings, and obvious emotional arousal. As with the Rorschach, however, there is more than one TAT scoring system. Some of them have used elaborate quantitative procedures that created TAT response norms to which clinicians can compare their clients' responses (Vane, 1981). Most others, though, make little use of formal scoring procedures, allowing the clinician to perform primarily qualitative (non-mathematical) analyses on the themes in the client's stories (Henry, 1956; Lilienfeld, Wood, & Garb, 2000). Still others combine preliminary quantitative analysis with a second, more subjective interpretation (Bellak, 1986; Ronan, Colavito, & Hammontree, 1993). Most clinicians seem to prefer TAT scoring systems that are relatively unstructured, even though these systems have limited reliability and validity.

Other Projective Tests. The *Rosenzweig Picture-Frustration Study* (Rosenzweig, 1949, 1977) is similar in many ways to the TAT, but it is designed to detect one specific trait, namely aggression. It presents 24 cartoons showing one person frustrating another person in some way (saying, for example, "I'm not going to invite you to my party"). The client's task is to say what the frustrated person's response would be. The cards of the *Children's Apperception Test* (CAT) (Bellak, 1992) depict animal characters rather than human beings; those of the *Roberts Apperception Test for Children* (RATC) (McArthur & Roberts, 1982) show children interacting with adults and other children.

Clinicians also use projective measures that take the form of *incomplete sentence tests*. The most popular of these is the *Rotter Incomplete Sentences*

Blank (Rotter & Rafferty, 1950). It contains 40 sentence stems such as "I like ___," "My father ___," and "I secretly ___." The client's response to each stem is compared to norms provided in the test manual and is then rated on a 7-point scale of adjustment–maladjustment based on how much the response deviates from those norms. Ratings for all the sentences are then summed to provide an overall adjustment score. There is more research support for Jane Loevinger's *Washington University Sentence Completion Test* (Hy & Loevinger, 2014). This psychometrically sophisticated measure is intended to assess what she called "ego development," a concept related to the maturation of a person's view of the world (Hy & Loevinger, 2014). According to Loevinger, for example, people at a relatively low level of ego development might complete the sentence "My most important goal in life is ____" by saying "to be liked by other people."

Some other projective tests ask people to draw images of people and/or other objects; these include the *Draw-a-Person* (DAP) test (Machover, 1949) and the *House–Tree–Person* (HTP) test (Buck, 1948). The client's drawings serve as a basis for the clinician's inferences about various aspects of the client's personality and also for discussion during an interview. Interpretive inferences are guided by projective assumptions that the inclusion, exclusion, and characteristics of each body part, along with the placement, symmetry, organization, size, and other features of the drawing, are indicative of the client's self-image, conflicts, and perceptions of the world (Machover, 1949).

The *Bender Visual Motor Gestalt Test* is a figure-copying test designed to measure certain aspects of mental ability, particularly neuropsychological functioning (Domino & Domino, 2006). Clients are shown geometric shapes on nine cards and asked to draw the shapes as accurately as possible. When used with children, the test is considered a measure of visual-motor

development, but some clinicians use the test as a projective personality measure, assuming that errors and distortions in the copied figures are indicators of a client’s personality. Psychometric evidence suggests that the Bender–Gestalt Test has more value for rough neuropsychological screening and assessment of visual-motor development than it does for personality assessment (Domino & Domino, 2006).

In Review Tests of Psychopathology and Personality

Title	Format/Purpose	Scoring
Objective (Structured) Tests		
Minnesota Multiphasic Personality Inventory (MMPI-2-RF)	388 True–False items/ Measurement of characteristics associated with psychological disorders	Scores on 9 clinical scales and 11 validity scales can be plotted as a profile.
Personality Assessment Inventory (PAI)	Four-point ratings of agreement with each of 344 statements/ Measurement of clinical symptoms	Scores on 11 clinical scales, numerous subscales, and 4 validity scales can be plotted as a profile.
Millon Clinical Multiaxial Inventory (MCMI-IV)	195 true–false statements/ Measurement of personality disorder symptoms	Scores on 25 clinical scales and five validity scales can be plotted as a profile.
Beck Depression Inventory	Ratings on a 4-point scale of the degree to which 21 statements apply to the client/ Assessment of depression	Total score is converted into a rating of degree of depression from none to severe.
Eysenck Personality Questionnaire	Yes-or-no answers about whether each of 100 statements apply to the	Scores on Introversion–Extraversion, Neuroticism–Stability, and

(EPQ-R)	client/ Measurement of personality dimensions.	Psychoticism.
NEO-PI-3	Ratings on a 5-point scale of the degree to which 240 statements apply to the client/ Measurement of main dimensions of personality.	Scores on Neuroticism, Extraversion, Openness, Conscientiousness, and Agreeableness are translated into a profile and a summary report.
California Psychological Inventory (CPI)	462 true–false items, based partly on the MMPI/ Measurement of main dimensions of personality.	Scores on 15 clinical scales and three validity scales can be plotted as a profile.
Projective (Unstructured) Tests		
The Rorschach Inkblot Test	10 inkblot cards/ Measurement of personality and pathology.	Client responses are coded into scores which are then interpreted as evidence of personality and pathology.
The Thematic Apperception Test	31 ambiguous drawings/ Measurement of personality and pathology.	Client responses are coded into scores which are then interpreted as evidence of personality and pathology.

Test Yourself

1. Tests such as the MMPI are typically based on ________ construction procedures.

2. The Myers-Briggs Type Inventory, is widely used in some nonclinical settings, and has very ______reliability and validity.

3. The Rorschach and TAT are based on the ________ hypothesis.

You can find the answers in the Answer Key at the end of the book.

The Current Status of Psychological Testing

Section Preview In this section, we take a broader look at psychological testing. First, we summarize the reliability and validity of psychological tests, and consider how their psychometric qualities stack up against those of medical tests. Next, we discuss how psychological testing has changed over the years, how its practitioners should adhere to the highest ethical standards, and how tests are now being used to guide the selection and evaluation of treatment.

Clinical psychological scientists are some of the toughest critics of psychological tests. Even when a particular test meets acceptable psychometric standards, these clinicians are often the first to point out any remaining shortcomings. This is a good thing, because focusing attention on a test's weaknesses stimulates efforts to improve it (Glaser & Bond, 1981). As a result, most of the tests we have described in this chapter are now in their third, fourth, or even fifth editions. Nevertheless, psychological testing remains controversial from a scientific point of view, partly because despite continuing improvements, every test fails to some degree—none is perfectly reliable, neither are they perfectly valid for all their intended purposes. There are also concerns about how the results of psychological tests are used, and potentially misused. Let's consider the psychometric question first.

Reliability and Validity of Psychological Tests

We have already mentioned that tests of intelligence are among the most reliable and valid of all psychological tests. For both children and adults, test–retest and split-half reliability figures are generally between + 0.85 and + 0.95 (Deary, 2012; Deary, et al., 2000; Roid, 2003; Watkins & Smith, 2013; Wechsler, 2014). Intelligence tests are also valid for predicting success in school and in many life situations and occupations (Borghans et al., 2016; Firkowska-Mankiewicz, 2011; Flanagan et al., 2011; Sackett, Borneman, & Connelly, 2008). Still, these tests do not measure all important dimensions of intellectual functioning; as we mentioned earlier, they are better at measuring speed and effectiveness of information processing than at measuring the capacity to think rationally (Stanovich, 2009). That shortcoming may help to explain why people who are very "smart" as defined by an IQ test might still cling irrationally to theories or ideas that have little or no scientific support (Vyse, 2013, 2018). For example, Linus Pauling, a Nobel Prize-winning chemist, became convinced that vitamin C could cure schizophrenia, cancer, and many other maladies (Hoffer, 2008).

Though not in the same league as intelligence measures, the MMPI-2-RF, the NEO-PI-3, and other major tests of personality and psychopathology (except for the Myers–Briggs Type Indicator) show acceptable levels of reliability and validity for most of their intended clinical uses (e.g. Butcher, 2013; Costa & McCrae, 2014; McCrae & Costa, 2010; Millon, Grossman, & Millon, 2015; Soto & Oliver, 2009).

Projective tests such as the Rorschach and the TAT generally come in last from a psychometric point of view. Test–retest and interrater reliabilities

for Rorschach scores have varied considerably. Results based on early scoring systems, in particular, were discouraging. Using one of the more recent Exner systems to score the Rorschach, advocates point to interrater reliability coefficients for some indices that average above 0.80 while others are considerably lower (Exner & Erdberg, 2005; Krishnamurthy et al., 2011). Similarly, both test–retest and interrater reliabilities for the TAT are quite low (Lilienfeld et al., 2000; Murstein, 1963; Rossini & Moretti, 1997). In short, evidence for the reliability of projective techniques is mixed, at best (Domino & Domino, 2006; Groth-Marnat, 2009; Hunsley & Mash, 2007; Krishnamurthy et al., 2011).

As for validity, the picture is even more mixed. For many years, for example, clinicians used the Rorschach to help them diagnose clients' psychological disorders, but research suggests that, with only a few exceptions (e.g., Mihura et al., 2016), inferences based on the test add little useful information, especially when compared with that coming from objective tests of psychopathology (Wildman & Wildman, 1975; Wood et al., 2000, 2003). The one notable exception is that the Rorschach possesses modest validity for detecting the kinds of thought disorder seen in clients with schizophrenia and bipolar disorder (Lilienfeld et al., 2000; Wood et al., 2015). But even here, it is not clear that Rorschach results provide information about such clients that goes beyond what a clinician could discover simply by talking to them for a few minutes. The questionable validity and utility of many or most Rorschach scores has led the Division of Clinical Psychology of the American Psychological Association to remove Rorschach courses from its recommended model assessment curriculum (APA Division 12 Task Force, 1999). Newer scoring systems for the Rorschach and new ways of measuring reliability and validity for the TAT

(e.g. Gruber & Kreuzpointner, 2013; Meyer & Eblin, 2012) may lead to somewhat improved psychometric properties, but research evidence for that improvement will have to be strong and uniform if these tests are to regain their former status, especially among clinical psychological scientists.

Is perfection the standard against which objective and projective tests should be judged? There are no perfect psychological tests, so what makes a test “good enough” to justify its use? One way to gain some perspective on these questions is to ask how the validity of psychological tests compares with that of medical tests. Many people, psychologists included, assume that when it comes to accuracy, psychological tests rank lower than medical ones, and perhaps a lot lower. However, in 1996, the American Psychological Association’s Board of Professional Affairs formed a Psychological Assessment Work Group (PAWG) to evaluate this assumption. When PAWG combined the results of 125 meta-analyses (which are statistical procedures for summarizing data from multiple studies) of the validity of medical and psychological tests, they found that—while some in each category are more valid than others—their average accuracy is about the same (Meyer et al., 2001). Although some authors have argued that the PAWG’s conclusions were based on questionable statistical assumptions and are therefore exaggerated (Garb, 2003), it does seem likely that many widely used psychological tests are about as valid as many common medical tests. Put somewhat differently, both medical doctors and clinical psychologists are using tests whose value for diagnosing and making predictions about patients’ disorders, for example, can range from very high to quite low. Obviously, there is considerable room for improvement in the validity of assessment instruments in both fields, but if we are to judge the adequacy of psychological tests by comparing their validity with that of medical tests,

psychological tests—especially objective (structured) ones—fare reasonably well.

Psychological Testing with Diverse Clients

You may recall from Chapter 1 that Rachel Jackson's maternal grandparents came to the United States from Lithuania. Her 70-year-old grandmother, Danutė Bagdonas, has been in poor physical health since before she immigrated at the age of 25. She has some difficulty walking and is now experiencing memory problems and episodes of confusion and disorientation. As we mentioned in Chapter 3, Lena eventually persuaded her mother to see Dr. Kramer, a clinical neuropsychologist who planned to administer a set of tests that included the Wechsler Adult Intelligence Scale (in Chapter 13, you can read about the other tests he planned to give). We also mentioned that Dr. Kramer quickly discovered that Mrs. Bagdonas speaks and reads English, but not well, and that this limitation, along with her mobility problems, have kept her from becoming as familiar with some aspects of U.S. culture as other European immigrants of her age. So, as he thought about beginning the WAIS, Dr. Kramer had to ask himself some questions. Will this client understand his instructions and the test items? Will she interpret the items in the same way as native English speakers would? Do the test's norms apply to Lithuanian immigrants?

The specific questions raised in this example introduce a broader one: To what extent do psychological tests adequately assess psychopathology, personality, intelligence, or other characteristics in diverse populations? In choosing their tests, and when interpreting test results, culturally competent clinicians look for empirical evidence that supports the applicability of various tests to clients from diverse sociocultural backgrounds. Were people from, say, Eastern Europe, Asia, Africa, and South America adequately

represented in the sample used to create a test’s norms? Is there a validated version of the test available in the client’s native language, or perhaps even one that was developed specifically for clients from Lithuania?

Because culturally specialized versions of psychological tests are rare, Dr. Kramer would want to seek research evidence about how WAIS scores might be affected by Mrs. Bagdonas’ cultural background. Having that evidence can help guide his interpretation of her test results. Awareness of such culture-specific effects have led to efforts by some test developers to create versions of standard assessments that will be reliable and valid for use with particular populations (Correa, Rogers, & Hoestring, 2010; Crowther et al., 2011; Hambleton, Merenda, & Spielberger, 2005). For example, there are now Spanish-language versions of the WAIS and the WISC (Wechsler, 2008b, 2017) and the Beck Depression Inventory (Beck, Steer, & Brown, 1996), a Chinese version of the 16PF personality test (Jia-xi & Guo-Peng, 2006), and translations of the MMPI into 25 languages (not including Lithuanian). Expect these efforts to adapt and translate major tests to continue and to expand in scope.

The Ethical Use of Psychological Tests

Trying to ensure that psychological tests are being used and interpreted appropriately with diverse clients is but one aspect of the ethical concerns that shape the testing activities of clinical psychologists. The American Psychological Association's *Ethical Principles of Psychologists and Code of Conduct* (American Psychological Association, 2017a), along with its *Standards for Educational and Psychological Tests* (1985; revised in 2013) provide clear guidelines to help its members minimize the possibility of inappropriate use or interpretation of tests (see Table 5.3). The second of these documents was developed jointly by the American Educational Research Association, the American Psychological Association, and the National Council on Measurement in Education. APA's *Guidelines for Test User Qualifications* provides additional information for those considering the use of tests. There are also *Uniform Guidelines on Employee Selection Procedures* published by the Equal Employment Opportunity Commission (EEOC) to regulate the use of tests and other methods as selection techniques. Together, these documents help ensure that psychological tests are being developed, evaluated, administered, interpreted, and published with proper regard for scientific principles and the rights and welfare of clients, and thus that they make a positive contribution to society (Robertson & Eyde, 1993).

Table 5.3 Ethical Standards for Psychologists' Use of Tests

Ethical Principle	Example of Applying the Principle
Competence	Clinicians should be experienced in the

	administration and interpretation of the tests they use to make decisions about clients.
Professional/scientific responsibility	Clinicians should be familiar with the research literature on a test, particularly its reliability, validity, appropriate uses, and limitations.
Integrity	Clinicians should use tests as intended and not make claims about tests or test results unless those claims are supported by empirical evidence.
Respect for rights and dignity	Clinicians should ensure that a test genuinely applies to those who take the test, especially people from different cultures.
Concern for others' welfare	First, clinicians should do no harm in using tests; they should recognize their potential for harm, especially if test results are inappropriately applied.
Social responsibility	Clinicians should not disseminate test materials or the protected content of tests to unauthorized people; they should take action to prevent the misuse of tests by others.
Access to test materials	Ethical practice prohibits test developers and users from making public the contents of certain psychological tests (such as IQ tests); tests are commercially available only to qualified users.

New Roles and Goals for Psychological Tests

As we describe in Chapter 2 the testing that was performed by early clinical psychologists were aimed mainly at identifying children's educational problems, assessing their intelligence, arriving at diagnoses, and helping to select individuals who qualified for certain occupations or military service. Once clinical psychologists began to expand their role as psychotherapists after World War II, they continued using psychological tests as much as before. They paid little attention to the question of whether these tests had *clinical utility*, that is, could be used to help them select or adjust their treatment methods or to evaluate the effects of those methods (Hunsley & Mash, 2007). Many of them also overlooked the key fact that even a test with extremely high validity may have little or no clinical utility.

Do tests of personality and psychopathology have clinical utility? Not necessarily. In one study, clients took the MMPI just prior to beginning psychotherapy (Lima et al., 2005). Half of the clinicians who treated these clients were informed about their clients' MMPI results, the other half were not. The researchers found that these clinicians made the same kinds of treatment plans, whether or not they had seen the clients' MMPI tests. There were no differences, either, in the results of treatment or whether clients dropped out early. In other words, data from the MMPI had no apparent effect on how these clinicians chose and conducted treatment. These results should not be too surprising, because tests like the MMPI were designed —and have the most validity—for describing personality and psychopathology, not for guiding selection and evaluation of treatment. Much more research is needed in this area (Garb et al., 2009) because, after all, if

the results of psychological tests don’t improve treatment outcomes in any way, clinicians have to wonder whether these tests are necessary in routine clinical practice.

Accordingly, the case is now being made for creating tests that *do* serve these purposes (Hunsley & Mash, 2007). Procedures for doing so are likely to focus on identifying the most important treatment variables and *then* develop tests specifically to measure those variables. A few such tests have already been developed. The *Outcome Questionnaire-45* (OQ-45) and the *Behavior and Symptom Identification Scale* (BASIS-32) are designed to measure treatment outcomes, and both have been shown to be sensitive to client changes over relatively short time periods. Both have also demonstrated convergent and discriminant validity (Ellsworth, Lambert, & Johnson, 2006). These instruments represent attempts to tie testing directly to treatment outcomes. They can also provide therapists with objective feedback about clients’ progress. In addition, since these measures are used widely, results of treatment outcome studies can be compared directly. Furthermore, it appears that providing regular feedback to therapists regarding clients’ scores on these outcome measures improves therapeutic outcomes (Lambert, Whipple, & Kleinstäuber, 2018), probably because therapists can immediately adjust treatment procedures when they discover that their clients aren’t doing as well as they thought. This last clinical use is especially important because there is evidence that, without regular feedback about progress, most therapists may fail to realize that some of their clients are getting worse during treatment (Lambert, 2015).

Among the other trends that we see on the horizon are these:

1. Tests that have survived decades of scrutiny will continue to be used. These include the Wechsler scales, the Binet scales, and the MMPI. However, the “old standby” tests will not simply stand by; under continued empirical scrutiny, changes in the population—and changes in the diagnostic system—these tests will undergo periodic revisions, including renorming.

2. Tests that show unacceptably low levels of reliability, validity, and utility will see diminished use. Projective tests such as the Rorschach (whose materials have not evolved, but whose scoring systems have) are unlikely to disappear because there is evidence that supports some of the scores derived from them and because clinical researchers continue to seek scoring systems that produce more reliable and valid measures. Eventually, however, we suspect that these tests will be replaced, perhaps by projective techniques with superior validity.

3. Testing will continue to expand and to improve the reliability and validity of instruments that will be used with ever more diverse client populations. As research yields information about administration and scoring modifications necessary for different cultural groups, these tests will be offered in many more languages.

4. Computers, smartphone, tablets, and other mobile devices will play an increasingly important role in assessment. This change will be a continuation of the existing trend toward computerizing many, if not all, paper-and-pencil tests for easier administration and faster, more sophisticated scoring. In addition, the increased capacity for realistic visual presentation (including virtual reality technology) and the local and remote recording of physiological activity promise to make new forms of testing much more dynamic and realistic. The ability of ever more sophisticated devices to

passively sense or directly record speech, sleep, movement patterns, and location will help to contextualize assessments and provide ever more nuanced information about clients.

5. Testing designed to aid in treatment planning and treatment outcome measurement will flourish. In this age of accountability, when objective demonstrations of treatment outcomes are critical, such tests will become increasingly important and more of them will be developed.

In Review The Current Status of Psychological Testing

Reliability and Validity	In general, the most reliable and valid psychological tests are those that measure intelligence, followed by objective (structured) tests of personality and psychopathology, and then projective (unstructured) personality tests.
Applicability	Norms for major intelligence tests are already based on diverse samples of people in North America, and efforts are underway to make those tests, as well as tests of personality and psychopathology, more applicable for use with people from other nations and cultures.
Ethical testing	The APA, other professional organizations, and the U.S. government have all established guidelines or laws designed to assure that psychological tests are used in the most ethically responsible ways, but monitoring and enforcement remain important for preventing or halting violations.
Future trends	Psychological tests will become ever more technologically sophisticated and will expand into areas such as guiding and evaluating treatment.

Test Yourself

1. Which of the following tests is likely to be more reliable, the TAT or the MMPI?

2. The three main categories of psychological tests, ranked from highest to lowest validity are: ______, ______, ______.

3. A test that can help a clinician choose the best treatment for a particular client is said to have ______________.

You can find the answers in the Answer Key at the end of the book.

Chapter Summary

Thousands of psychological tests are available today, and more are being developed. Tests are built using analytic (theoretical) procedures, empirical procedures, and often both. An empirical approach is needed to develop test norms, without which test score interpretation is difficult. Norms typically come from a large, representative standardization sample. Even after finding representative samples, test developers and users must exercise caution in order to avoid the bias that could occur if tests do not "fit" people from differing sociocultural backgrounds.

The psychological tests commonly used by clinical researchers and practitioners can be categorized by what they measure: cognitive-intellectual abilities, interests and values, and personality and psychopathology. Tests can also be categorized by the way they measure constructs. Those that present simple, unambiguous, and easily scored items (e.g., true or false) are called objective (structured) tests. Those that request complex verbal or graphic responses to ambiguous stimuli (e.g., an inkblot) are called projective (unstructured) tests.

Prominent objective tests of intellectual functioning (whose results are usually expressed as IQ scores) include the Stanford–Binet 5 and the Wechsler scales (e.g., WAIS-IV, WISC-V). The SAT and the Wide Range Achievement Test (WRAT5) exemplify some of the general ability tests in use today. Attitudes, interests, preferences, and values are typically measured through tests such as the Strong Interest Inventory, the Self-Directed Search, the Study of Values, and the Rokeach Values Survey.

The most widely used test of personality and psychopathology in clinical settings is the Minnesota Multiphasic Personality Inventory (its most recent version is the MMPI-2-RF). The Personality Assessment Inventory (PAI) and the Millon Clinical Multiphasic Inventory (MCMI-IV) are commonly used in clinical settings. There are many tests designed to measure specific areas of difficulty rather than personality, as broadly conceived. The Beck Depression Inventory (BDI-II) is a prominent example. Several tests are designed to measure normal personality; the NEO-Personality Inventory (NEO-PI-3), the California Psychological Inventory (CPI), and the Sixteen Personality Factor Questionnaire (16PF5e) are examples.

The Rorschach, the Thematic Apperception Test (TAT), sentence completion tests, and the Draw-a-Person (DAP) test are projective instruments designed to measure aspects of personality and psychopathology. Once the most popular tests used by clinicians, they are used less often now because of concerns about their psychometric properties. However, because many clinicians are convinced of their utility, clinical research designed to improve the reliability and validity of these tests continues.

The testing enterprise continues because tests can be useful and because clinical traditions and societal demands maintain its importance. With time, those tests that do a poorer job will be replaced, and tests that more clearly translate into treatment planning and evaluation will be more common.

6

Basic Features of Clinical Interventions

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Contents

Overview of Clinical Interventions

The Participants in Psychotherapy

The Goals of Clinical Interventions

Ethical Guidelines for Clinical Interventions

Some Practical Aspects of Clinical Intervention

Chapter Preview

In this chapter, we describe features common to most clinical interventions, focusing primarily on psychotherapy. We begin by examining what psychotherapy is and contrasting it with how it is portrayed in popular media. We describe what research tells us about clients and therapists and which of their characteristics influence therapy outcomes. Next, we examine the goals and basic processes involved in clinical interventions, as well as the professional and ethical codes that help guide practitioners in conducting treatment. Finally, we consider certain practical aspects of treatment such as treatment duration, fees, record keeping, treatment planning, therapist self-disclosure, and termination.

Overview of Clinical Interventions

Section Preview Here we offer a formal definition of psychotherapy and contrast that definition with the usually inaccurate portrayals found in popular media. We then describe how the hundreds of available psychotherapy approaches can be organized into just a handful based on shared assumptions and practices.

Clinical interventions occur when clinicians, acting in a professional capacity, attempt to change a client's behavior, thoughts, emotions, or social circumstances in a desirable direction. Intervention can take many forms, including individual, couples, family, and group psychotherapy, psychosocial rehabilitation, and prevention, but psychotherapy is the intervention activity by which clinical psychologists are best known.

What Is Psychotherapy?

In a nutshell, **psychotherapy** can be defined as treatment techniques administered by trained mental health professionals within a professional relationship to help clients overcome psychological problems. While no definition of psychotherapy satisfies everyone, this one identifies psychotherapy's participants (clients and therapists), its basic framework (professional relationship), and its main goal (behavior change for the better). The definition is, however, rather formal and probably not what comes to mind for most people when they hear the word *psychotherapy*.

Psychotherapy
Treatment techniques administered by mental health professionals in a professional relationship to help clients overcome psychological problems.

Public (Mis)Perception of Psychotherapy. The image of psychotherapy created in the public mind by movies, television, and other popular media looks something like this:

> *Two people are meeting in a private office. They may be sitting on comfortable chairs, or perhaps one of them, the client, is lying on a couch. The client talks about troubling events while the therapist asks probing questions or offers encouragement for the client to say more*

(e.g., "uh huh," "I see," "Tell me more about that," "And how did that make you feel?"). Over time, the therapist gradually directs the client to focus on emotionally painful events from childhood, events that had been buried in the unconscious. Once the client has fully remembered and discussed these issues, the client improves.

This scene contains some elements of truth, but it is mainly a caricature or stereotype (much like media images of police detectives, medical personnel, attorneys, and judges). In movies and on television, clinical psychologists (and psychiatrists) frequently fail to maintain appropriate professional boundaries, and they violate ethical codes, or shoot from the hip in offering diagnoses and treatment rather than relying on evidence-based interventions (Cannon, 2008; Orchowski, Spickard, & McNamara, 2006). The methods employed in treatments also tend to be inaccurately portrayed or oversimplified, probably because screenwriters and filmmakers formed their impressions of therapy from media portrayals! Stereotyped versions of psychoanalysis, in particular, are repeated with surprising regularity, and usually revolve around the unearthing of a traumatic memory (Gabbard & Gabbard, 1999). These portrayals are so prevalent that some observers have suggested using media depictions of psychotherapy to teach clinicians how *not* to do psychotherapy (Gabbard & Horowitz, 2010).

There are also media misrepresentations of the effects of psychotherapy. Consider, for example, a *Newsweek* article (Begley, 2007) describing efforts by psychologist Scott Lilienfeld and others to distinguish ineffective or harmful psychological treatments from the effective ones (see Lilienfeld, 2007). The article's title, "Get Shrunk at Your Own Risk," implied that all forms of psychotherapy may be risky (to "get shrunk" is slang for receiving

psychotherapy treatment, just as “a shrink” is slang for a psychotherapist). It *is* true that clinical researchers have found that some forms of psychotherapy can cause more harm than good (see Chapter 10), but as described throughout this book, it is also true that empirically supported treatments are quite beneficial.

Inaccurate portrayals of psychotherapy can not only mislead the public about the work of mental health professionals, but can also discourage troubled people—such as Rachel Jackson’s father James—from seeking treatments that could help them, while at the same time perpetuating stereotypes about mentally ill people (Maier et al., 2014). So let’s set the record straight by considering what psychotherapy really involves, and summarizing the many kinds of psychotherapy that are available.

How Many Psychotherapy Approaches Are There?

There are at least 600 “brand name” therapies and that number is almost certainly growing (Lilienfeld, Lynn, & Lohr, 2014). These therapies literally run the gamut from A (Aikido) to Z (Zaraleya psychoenergetic technique) (Herink, 1980). However, many types of therapies are quite similar, and many of the others are rarely used by, or even known to, most clinicians. So it has been suggested that only about a dozen “essential” forms of psychotherapy are at the core of modern clinical practice (Messer & Gurman, 2011). In other words, no one knows exactly how many kinds of psychotherapy there are because the answer depends on how you group them. We think it makes sense to group them according to the six major approaches that we described in Chapter 2, namely psychodynamic, humanistic, behavioral, cognitive, cognitive behavior and acceptance-based, and social systems. In Chapters 8 and 9, you will see that the specific treatment methods within each major approach can vary somewhat, and, in Chapter 10, you will see that they can be delivered in widely different ways, such as in couples, groups, families, and whole communities, and through the use of digital technology.

In Review Major Approaches to Psychotherapy

Approach	**Description**
Psychodynamic	Emphasizes exploration of unconscious conflicts and other psychological forces that underlie behavior disorders.
Humanistic	Emphasizes use of the client–therapist relationship to create conditions in which clients recognize and act on genuine feelings and reach their full growth potential.
Behavioral	Emphasizes techniques derived from learning theory to identify and alter specific behaviors associated with psychological disorders.
Cognitive, cognitive behavior, and acceptance based	Emphasizes development of cognitive skills, especially for identifying unhelpful thinking, evaluating and modifying beliefs, learning to observe even painful thoughts and experiences without criticizing our reactions to them, and thus changing problematic behaviors, regulating emotions, and relating to others in new ways.
Social systems	Emphasizes the influence of social and cultural forces operating in clients' lives, including experiences of poverty or discrimination. Often conducted in group and family formats.

Test Yourself

1. Psychotherapy is defined as treatment procedures provided within a ______________.

2. Media misrepresentations of psychotherapy can make it _______ likely that troubled people will seek the help they need.

3. Psychotherapies can most logically be grouped according to their theoretical _________ to behavior and behavior disorder.

You can find the answers in the Answer Key at the end of the book.

The Participants in Psychotherapy

Section Preview Here we discuss clients and therapists, focusing on the characteristics of both that are important to successful treatment. We also describe the therapeutic relationship as an important component of treatment and end by describing the settings in which clinical interventions typically occur.

Psychotherapy involves at least one client and one therapist, though it can involve more than one client at a time (as in couples, family, or group therapy) or more than one therapist at a time (e.g., co-therapists, therapeutic teams). Clients and therapists can vary in many ways, including in terms of age, gender, gender identity, racial or ethnic background, sexual orientation, belief systems, personal strengths and weaknesses, communication styles, and so on. Let’s first examine the problems and personality characteristics that clients bring to psychotherapy.

The Client

People seek physiotherapy for a variety of reasons. Depression, anxiety, the impact of illness, injury or trauma, relationship difficulties, lack of self-confidence, facing an identity crisis, sexual problems, and insomnia are just a few of the most prominent examples. When problems are serious enough to impair a person's day-to-day functioning or create a risk of suicide or harm to others, hospitalization may be necessary. Most people's problems are less extreme, but still very distressing. The common essential feature of therapy clients is that their usual coping strategies—such as utilizing the support of friends and family or taking a vacation—are no longer sufficient to deal successfully with their problems.

Client Problems and Treatment Utilization. Mental disorders are found, with only minor variations, in all segments of society in the United States and around the world. Which disorders are the most common? In the United States, when clients are given DSM diagnoses, anxiety disorders top the list, with mood disorders, impulse-control disorders, and substance abuse disorders not far behind (National Institute of Mental Health, 2006). Disorders can occur at any point in life, but the more serious ones usually appear early, often by age 14. If untreated, these disorders are more likely to continue, and may worsen (Kessler et al., 2005). About 80% of suicide attempts in the United States are made by people with a mental disorder, especially anxiety, mood, impulse-control and substance-use problems (Nock et al., 2010).

Unfortunately, not everyone who experiences psychological disorders seeks treatment, often because of cost but also because of the stigma

associated with entering therapy or, as described in Chapter 10, because of limited access to mental health services (Chekroud et al., 2008). Evidence for the underutilization of psychotherapy comes from several large-scale studies, including the National Comorbidity Survey Replication. That study estimated the 12-month prevalence rates for anxiety disorders to be 18%, and 26% for any disorder (Kessler et al., 2005), but as you can see in Figure 6.1, far less than 10% of people in any demographic group tends to enter treatment.

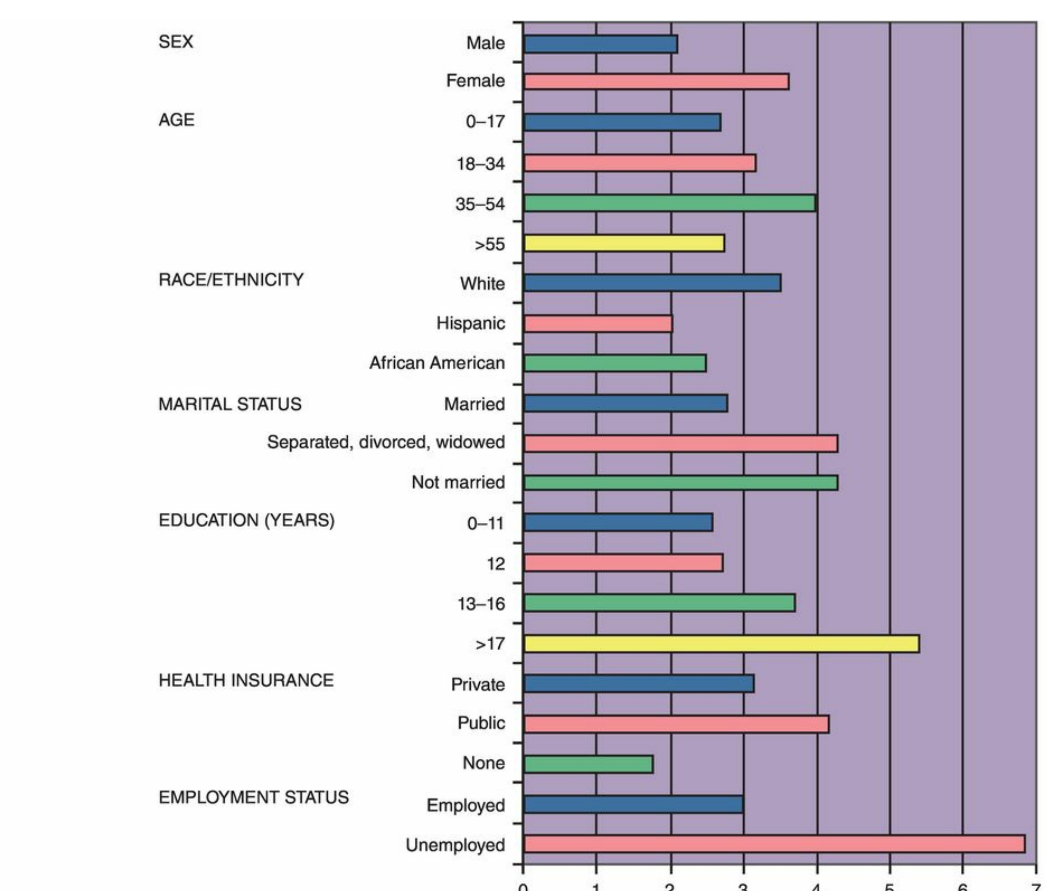


Figure 6.1 Outpatient Psychotherapy Utilization by Demographic Characteristics

This figure shows the number of individuals per 100, in different demographic categories, who used mental health services in the United States in one recent year. Those seeking psychotherapy are more likely to

be middle aged, educated, white, female, and divorced or separated, to have public insurance, and to be unemployed. Members of minority and lower socioeconomic groups are less likely to enter treatment, and more likely to drop out prematurely (Olfson & Marcus, 2010).

(Source: Data from Olfson, M., & Marcus, S. C. (2010). National trends in outpatient psychotherapy. *The American Journal of Psychiatry, 167,* 1456–1463; based on samples of over 29,000 in 2007.)

Low utilization rates remain despite the increasing availability of treatment options (Kerridge et al., 2017) and increased government spending on treatment for certain disorders (e.g., depression). Part of the reason is that the spending tends to be in support of drug treatment rather than psychotherapy (Fullerton et al., 2011). Unfortunately, the net increase in spending for drug-oriented treatment of depression appears to have resulted in only minimal improvements in the quality of care and has failed to connect more patients to their preferred treatment—which, by a factor of three to one, is psychotherapy over medication (McHugh et al., 2013).

Client Variables and Treatment Outcomes. When it comes to selecting treatments and predicting outcomes for those who do enter psychotherapy, one of the most important client variables is the nature of the problem to be addressed. Although some researchers have argued that a client's diagnosis has "largely failed as a basis for selecting among treatments" (Beutler & Harwood, 2000, p. 11), the evidence reviewed in Chapters 7 and 9 suggests that this is an overgeneralization. For example, behavioral and cognitive behavior therapy for some diagnoses, such as posttraumatic stress disorder (PTSD) and obsessive-compulsive disorder

(OCD), appear to be more effective than other psychotherapies (Foa & McLean, 2016).

Are there other client characteristics that might predict successful treatment outcomes? Broad demographic variables such as the clients' sex, age, ethnicity, socioeconomic status, intelligence, religious attitudes, and dozens of other personality and demographic variables have all been considered, but these tend to be relatively poor outcome predictors (Garfield, 1994; Kim & Zane, 2010).

What about clients' attitude toward treatment? Conventional wisdom holds that client motivation to change is directly related to therapeutic outcome. Consistent with this view is research showing that increases in motivation over the course of therapy is related to decreases in symptoms (Merrill et al., 2017). If we think of motivation in behavioral terms, it makes sense that two client variables—*cooperation* versus *resistance* and *openness* versus *defensiveness*—consistently show up as important to psychotherapy outcomes (Orlinsky, Grawe, & Parks, 1994; Teasdale & Hill, 2006). Motivation can be influenced by clients' beliefs and expectations, so it is not surprising that those who have more hope of improvement and less fear of change are more willing to engage with treatment (Holtforth Krieger, Bochsler, & Mauler, 2011; Messer, 2006). For example, willingness to fully experience unpleasant and unwanted thoughts, emotions, and bodily sensations during the exposure treatments described in Chapter 9 is a predictor of successful therapy for adult OCD (Reid et al., 2017). Clients' level of distress and coping style (e.g., externalizing or internalizing) are also important (Harwood, Beutler, & Groth-Marnat, 2011).

Autonomy, defined as a client's freedom and willingness to exercise choices, is also linked to outcomes (Ryan et al., 2010; Scheel, 2011). An

example of the autonomy variable is clients' preferences about the type of treatment they are to receive. One meta-analysis of 26 outcome studies found that clients who received a preferred treatment had a slightly but significantly, greater chance of improving and were half as likely to drop out of treatment (Swift & Callahan, 2009). Other research shows that allowing patients with PTSD to choose their preferred treatment resulted in better quality of life than either assigning them a treatment or giving them a nonpreferred treatment (Le, Doctor, Zoellner, & Feeny, 2018). Preferred treatments do not always work better, though. One study found that patients who were matched to their preferred treatment for depression were more likely to complete treatment but not more likely to improve (Dunlop et al., 2017) and a meta-analysis of 29 randomized clinical trials found the same (Windle et al., 2019). Several other client variables, including attachment style, previous trauma, tendency toward somatization, and social context have also been shown to have small to modest effects on outcome (van Manen et al., 2012).

In short, though clients' presenting problems are often the first consideration in selecting treatment and predicting its outcome, other demographic and personality variables can also be important. Indeed, it has been suggested that "it is frequently more important to know what kind of patient has the disorder than what kind of disorder the patient has" (Messer, 2006, p. 39).

The Therapist

Like clients, therapists can differ in many ways. The question of how and why some therapists achieve better results than others has been a major focus in recent years (Castonguay & Hill, 2017). As a general rule, therapists' broad demographic characteristics—things like age, sex, ethnicity, or socioeconomic status—play relatively insignificant roles in the overall effectiveness of therapy (Beutler, Machado, & Neufeldt, 1994; Stirman & Crits-Christoph, 2011), while others appear to have stronger effects.

Traits and Skills of Effective Therapists. Many authors (e.g., Brems, 2001; Cormier & Hackney, 2012; Inskipp, 2000; Jennings & Skovholt, 1999; Sommers-Flanagan & Sommers-Flanagan, 2012) have suggested that effective therapists possess a set of basic skills and traits. One of these—strong interpersonal skills—is related to the fact that psychotherapy is an interpersonal activity, so psychotherapists who are skilled at *communication, relationship-building*, and *self-monitoring* should have an edge (Inskipp, 2000). For example, therapists who can recognize differences and intensities in clients' emotional experiences, and who have a verbal repertoire capable of putting these perceptions into words, are more likely to effectively communicate their understanding to their clients. Having these communication skills can also help clients learn a new psychological vocabulary, find new ways of understanding their problems, and thus pave the way for the behavioral, cognitive, and emotional changes that are the goals of therapy.

As we describe later, the relationship that develops between therapist and client can strongly affect therapy outcome, so it is no wonder that a

therapist's relationship-building skills are critical (Decker et al., 2013). Therapists need to communicate sincerity and to warmly support troubled clients without judging them, but also to be firm in reminding clients of their capacity and responsibility for making beneficial changes in their lives.

Broad skills such as communication, relationship building, and self-monitoring are known as *macroskills;* they are essential regardless of the therapist's theoretical orientation and treatment approach. But the impact of various therapist traits may depend on how those traits interact with other factors, such as the length of treatment. Some research has shown that clients of therapists who are active, engaging, and extroverted, tend to improve faster than those of less active and more cautious therapists, but mainly when treatment is relatively short. In longer-term therapy, clients tend to do better with less active therapists (Heinonen et al., 2012).

Therapists' *intra*personal characteristics—such as having a secure attachment style, good coping and self-management skills, clear self-awareness, and a positive attitude toward clinical work—have also been associated with somewhat better therapy outcomes (e.g., Heinonen & Nissen-Lie, 2019; see Table 6.1). For example, as in any other line of work, the ability to monitor internal variables that might interfere with performance is important. This skill, known as *self-monitoring,* is seldom explicitly taught in clinical psychology training programs; ideally, it is learned implicitly as clinical training and supervision proceed. In psychoanalytically oriented training, for example, therapists' self-monitoring skills may be enhanced by undergoing their own analysis in an effort to better understand themselves. Cognitive or behaviorally oriented therapists are more likely to take a more empirical approach, but the goal is the same, namely to recognize and moderate their biases and culturally based (mis)perceptions (Burns, 1999).

Whatever the approach, in order to provide the best possible service, all therapists need to monitor the ways in which personal characteristics might be affecting their clinical work in a negative way.

Table 6.1 Characteristics of Effective Psychotherapists
Here is a summary of the interpersonal and intrapersonal skills that research suggests help to lay the foundation for effective psychotherapy. The importance of these skills cannot be overstated (Messer, 2006). Though having these skills does not guarantee successful treatment, the potential benefits of even the best evidence-based treatments can be reduced or eliminated in the hands of an unskilled therapist.

Characteristics of Master Therapists (adapted from Jennings & Skovholt, 1999)	**Selected Traits of Effective Mental Health Professionals (adapted from Brems, 2001)**	**Helper Qualities and Skills (adapted from Cormier & Hackney, 2012)**
Voracious learners who draw heavily on accumulated experience	Sense of ethics and professionalism	Virtue, including making clients' well-being the top priority
Aware of how their emotional health impacts their work	Willingness for introspection and self-reflection	Mindful awareness of experiences
Emotionally receptive, valuing cognitive complexity and ambiguity	Cognitive complexity and tolerance for ambiguity	Social justice orientation; appreciation of diversity and multiculturalism

Possess strong relationship skills	Cultural sensitivity and respect for others	Cultural competencies
Mentally healthy, mature, and attend to their own well-being	Personal mental health, self-respect, and appropriate use of power	Resiliency, positive orientation and stamina, especially in the face of adversity
Belief in the working alliance	Empathy and capacity for intimacy with good personal boundaries	

Therapist Training and Experience. It seems obvious that therapists need advanced training, and research partially supports this view. One study found that trained therapists could recognize others' emotions better than untrained novices could (Machado, Beulter, & Greenberg, 1999). This is a critical skill for understanding another person and for expressing empathy. Therapists with more training and experience also tend to have lower client dropout rates (Luborsky, 1989; Swift & Greenberg, 2012).

However, other research suggests that the relationship between treatment outcomes and therapist training and experience is not a consistently positive one. For example, treatment outcomes are sometimes no better for more experienced clinicians than for less experienced clinicians, or trainee therapists (e.g., Budge et al., 2013). One study even found that therapists' effectiveness did not improve with experience; in fact, it declined very slightly over time (Goldberg et al., 2016a, b). It has been suggested that these results occurred partly because of methodological problems that obscured the true importance of therapist training and experience (Leon et al., 2005).

Specifically, some of the studies that found trainees to be as effective as more experienced therapists focused on a narrow range of outcome variables (e.g., clients' ability to use a specific cognitive behavioral skill for anxiety). Re-analyses that look at a broader set of outcome variables (e.g., case conceptualization and planning, diagnosis, emotion recognition, need for further evaluation, dropout rates) often find that more experienced therapists in fact do better than less experienced ones (Eells et al., 2011; Swift & Greenberg, 2012).

Another reason that level of experience does not always clearly translate into improved outcomes is that therapists typically change the nature of their practice and the kinds of problems they encounter as they move through their careers. One survey (Pingitore & Sheffler, 2005) found that clinicians with less than 5 years of experience were more likely to work in public health and/or mental health settings than were those with more experience. Clinicians with more experience were more likely to be in private practice. Less-experienced psychologists also saw a higher percentage of clients with childhood disorders and substance abuse disorders, and they saw only about 19 clients per week (compared to about 25 per week for clinicians with 11 to 20 years of experience). If clinicians are more likely to begin their careers in public, community mental health settings before moving into private practice, and if they take on more cases, and tougher cases, in later years, their overall success rate may eventually suffer, but not because experience doesn't help.

Perhaps the best way to summarize research in this area is to say that psychotherapy training and experience has a small, but positive, effect on trainees' ability to foster positive outcomes with their patients over time (Walsh et al., 2018), but that the effect may vary as a function of the severity of the patient's symptoms. For example, psychotherapy trainees have

demonstrated growth over time in working with patients who were only moderately distressed, but there was no change over time for trainees when working with more severely distressed clients (Owen et al., 2016). Inconsistent findings about the value of clinical training may also suggest that it is not the *quantity* of training experiences but rather the *quality* that is important. The fact is that none of the core mental health professions, which include clinical psychology and psychiatry, can offer convincing evidence that their professionals produce therapy results that are superior to those of therapists in other fields. Indeed, as we describe in Chapter 10, paraprofessionals or other non-specialist providers (NSPs) who have only relatively brief and narrowly focused training sometimes produce results at least equal to those of professionals with many years of training (Forand et al., 2011).

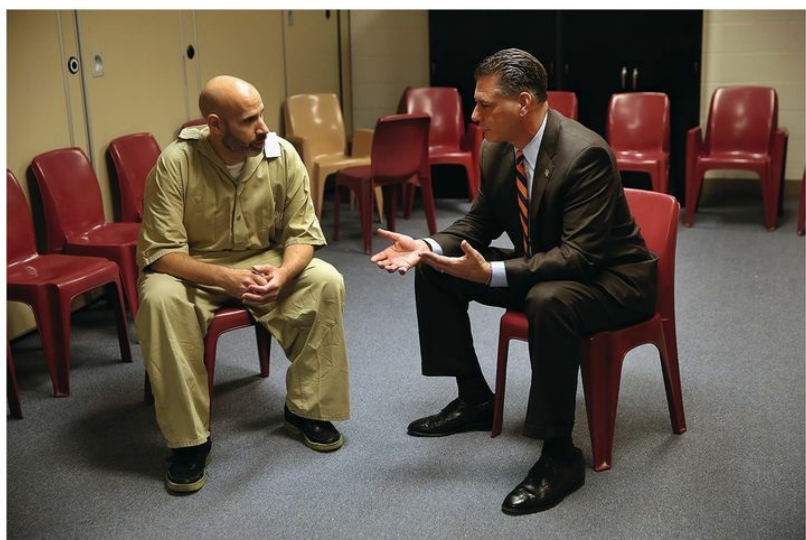
Challenges in Therapeutic Work. Providing psychotherapy services can be deeply rewarding. For those with a desire to help others, every day presents a new opportunity to make it easier for someone to improve and flourish. However, the work also has its challenges. Some are relatively minor irritations and frustrations, while other problems are more distressing and may cause clinicians to question their competence or character. Too often, therapists feel that their graduate training was inadequate in helping them to manage these emotions or to use them therapeutically (Pope, Kieth-Spiegel, & Tabachnick, 2006). The problems that therapists report in their work typically fall into the following three groups (Schröder & Davis, 2004):

1. *Competency-related*. These difficulties are relatively transient and result from situations in which therapists question whether they have the knowledge or skills to be effective in a given situation. For example, when a client being

treated individually for depression wants to begin couples therapy with her alcoholic husband, the therapist wonders if he is qualified to treat substance abuse and marital problems in addition to the depression.

2. *Personality-based*. This category includes therapists questioning the degree to which their own personal characteristics are compromising their effectiveness. For example, therapists sometimes wonder if they are deficient in some of the traits listed in Table 6.1.

3. *Situational*. These concerns result from characteristics of the therapists' client base or work situation. For instance, therapists who work with treatment-resistant violent sex offenders in a prison may have both competence and personal capacity but still find the work very difficult and draining.



A Tough Job

Some clinical psychologists find it rewarding to work with incarcerated clients, but others may eventually find it so difficult that they decide to seek an alternative work setting.

(Source: Boston Globe/Getty Images.)

How do therapists prepare for and cope with these challenges? The obvious fix for competency-related difficulties is to obtain more training in specified areas. When therapists struggle with certain clients (e.g., those diagnosed with a particular kind of disorder, or those from a particular cultural background or sexual identity), it may be because of deficits in their own knowledge and skills. If training for working with such clients was not available at a therapist's graduate training program, it can be obtained later through continuing education workshops or seminars offered by the APA or other professional organizations. Indeed, as described in Chapter 15, continuing education is typically a requirement for renewing one's license as a clinical psychologist. Participation in such training also demonstrates the commitment to ongoing professional development that all health-care providers should display.

Thinking Scientifically Should Psychotherapists Be Required to Have Therapy Themselves?

Sometimes, therapists' difficulties in working effectively with their clients are related to their own personal problems which, just like anyone else, can include depression, relationship problems, self-esteem concerns, anxiety, and burnout (Bearse et al., 2013; Kleespies et al., 2011b).

What am I being asked to believe?

Many clinicians believe that, in such cases, therapists should address their problems by seeing a therapist themselves. Indeed, one national survey found that about 54% of psychologists believe that personal

therapy should be required for licensing in clinical psychology (Murdock, 2004). This is a controversial idea. About 40% of respondents in that same national survey said that personal therapy should "absolutely not" or "probably not" be required for licensing (the remaining 6% said "don't know").

What kind of evidence is available to support the claim?

Support for the idea of therapists getting therapy, including for licensing purposes, is based partly on evidence suggesting that therapists' biases and personal problems can have negative effects on the quality of their treatment services. Indeed, as mentioned earlier, personal therapy has long been regarded as an important aspect of psychotherapy training for psychoanalysts and some other psychodynamically oriented therapists (Murdock, 2004).

Although few other types of graduate training programs specifically require personal therapy, survey evidence shows that about 85% of psychotherapists have sought treatment at least once, either during their graduate training or, more often, afterward (Bike, Norcross, & Schatz, 2009; Orlinsky et al., 2011). That percentage has been growing over the last 40 years, possibly because this same survey evidence suggests that more than 90% of clinicians who entered treatment report that therapy led to a number of positive outcomes (Bike, Norcross, & Schatz, 2009).

Are there alternative ways to interpret the evidence, including those that my biases and preconceptions might have kept me from seeing?

Survey evidence supports the self-reported value of personal therapy, but is that kind of evidence strong enough to justify making the therapy experience a requirement for licensure? A recent review of the literature in this area suggests that requiring psychotherapy for therapists can have both advantages and disadvantages (Murphy et al., 2018). Among the advantages are providing therapists with an opportunity to enhance their personal and professional development, to have an intense, real - world therapy experience from the client's point of view, and to become a more mentally healthy person. The potential disadvantages are related to ethical questions, including whether trainees should be required to have an experience that, in a small percentage of cases, could have negative effects, and whether the benefits of therapy will outweigh the negative effects of what some trainees might see as unjust interference with their right to decide about entering treatment. The cost of therapy also raises questions about whether it is ethical to require trainees to incur (further) debt to meet a requirement, and whether trainees will fully and authentically engage in the therapeutic process. If they simply "go through the motions" of being a client, the therapy enterprise could be a waste of time and money.

What additional evidence would help to evaluate the alternatives?

Conflicting views about requiring personal therapy for all licensed clinical psychologists are based partly on the question of whether it makes therapists more effective. The majority of clinicians believe that it does (Murdock, 2004), but there is also research evidence suggesting that it does not (Bike, Norcross, & Schatz, 2009). A

considerable amount of high-quality research on the question will obviously be needed if the field of clinical psychology, and its state licensing boards, are to be guided by data rather than opinion.

What conclusions are most reasonable given the kind of evidence available?

The need for more research on the effect of therapy for therapists in no way demeans the value of psychotherapy itself. As described in Chapters 7 through 10, empirical research has shown various forms of psychological treatment to be very effective in helping a wide variety of people with a wide variety of problems. The question here is whether therapy that is effective for someone who happens to be a psychotherapist will make that person a *better* psychotherapist. Until there is more and better research available to answer that question, it will be difficult to draw a rational conclusion about the value of requiring personal therapy for clinicians. So far, the evidence in support of the intended outcomes of personal psychotherapy during training is relatively weak (Edwards, 2018), and the ethical and other questions raised about this requirement cannot be ignored. Accordingly, we think that the safest bet for now is to allow trainees and postdoctoral therapists to decide this matter for themselves, and for state legislatures to withhold judgment about adding a personal therapy requirement to licensing laws.

The Therapeutic Alliance

In a sense, there is always a “third participant” in any therapeutic encounter: namely, the relationship between client and therapist. From the moment of first contact, each develops impressions, thoughts, and feelings about the other. As they move into extended interaction, these impressions begin to coalesce into a sense of what it is like to relate to this other person. The therapeutic relationship has many dimensions, but two of them are especially important: (a) the emotional bonds that develop between the therapist and client (liking, trust, etc.), and (b) the shared understanding of what is to be done (tasks) and what is to be achieved (goals) in treatment.

Together, these dimensions are often called the **therapeutic alliance** (see Bohart & Wade, 2013; Martin, Garske, & Davis, 2000). It refers to the way the client and therapist connect, behave, and engage with each other. The therapeutic alliance is important because research consistently finds that the quality of this relationship is associated with treatment outcomes (e.g., Crits-Christoph, Connolly-Gibbons, & Hearon, 2006; Flückiger et al., 2018; Horvath et al., 2011; Jennissen et al., 2019).

Therapeutic alliance

The emotional bond between therapist and client and their shared understanding of treatment tasks and goals.

Views of the Therapeutic Alliance. No one deserves more credit for drawing attention to the therapeutic alliance than Carl Rogers (1942, 1951), the founder of client-centered therapy. Rogers believed that a productive alliance will develop naturally if the therapist conveys to the client what he called *genuineness*, *empathy*, and *unconditional positive regard* (for details, see Chapter 8). Some evidence for this assertion comes from a meta-analysis showing that the strength of the therapeutic alliance was positively and significantly related to clients' perceptions of their therapists' empathy and genuineness (Nienhuis et al., 2018).

Rogers also said it is the relationship itself—not specific treatment techniques—that acts as the main curative factor in psychotherapy. Humanistically-oriented therapists today hold a similar view. To them, the alliance is not merely the context for treatment, it *is* the treatment. Other clinicians are not so sure (Ewbank et al., 2020). For example, psychoanalysts and psychodynamically oriented clinicians see the alliance mainly as a therapeutic pact—a shared understanding about the professional relationship and the kinds of interactions that take place within it (Meissner, 2006).To them, the alliance sets the stage for administration of the therapy techniques that actually drive client improvement. Most behavioral and cognitive behavioral therapists also view the therapeutic relationship as an important but not sufficient treatment ingredient (Sweet, 1984). It is seen as the foundation for many aspects of clinical interventions, from enhancing clients' motivation and setting a treatment agenda to introducing specific treatment techniques and implementing them effectively (Kazantzis, Dattilio, & Dobson, 2017).

An Emotional Bond

A strong alliance can build a therapist's credibility with clients, such that when they demonstrate new skills for clients to try, and when they provide praise for progress, their influence is strong enough to promote beneficial changes (Follette, Naugle, & Callaghan, 1996; Kohlenberg & Tsai, 1991).

(Source: Phatcharee Saetoen/EyeEm/Getty Images.)

Research on the Therapeutic Alliance. It is clear that therapists with different theoretical orientations have differing views of the role and importance of the therapeutic alliance (Norcross & Lambert, 2011). Let's now consider some of what researchers have found in their efforts to better understand the alliance and the mechanisms through which it has its effects. One of their first steps was to develop instruments for measuring the alliance (Ardito & Rabellino, 2011). The most prominent of these instruments are the *Pennsylvania (Penn) Scales* (Alexander & Luborsky, 1986), the *Working Alliance Inventory* (Horvath & Greenberg, 1989), the *California Psychotherapy Alliance Scales* (Marmar et al., 1989), the *Vanderbilt Psychotherapy Process Scale* (Suh, Strupp, & O'Malley, 1986), the *Toronto Scales* (Marziali et al., 1981), the *Psychotherapy Status Report (PSR;* Frank

& Gunderson, 1990), the *Agnew Relationship Measure* (ARM; Agnew-Davies et al., 1998), the *Therapeutic Bond Scales* (Saunders, Howard, & Orlinsky, 1989), and the *Kim Alliance Scale* (KAS; Kim et al., 2001). Some of these scales were designed with specific theoretical views of the alliance in mind (e.g., psychodynamic), while others aim to measure the alliance more generally. Most of them are strongly intercorrelated, which suggests that they are measuring closely related or overlapping concepts.

Meta-analytic reviews of studies using instruments like these have clearly established a positive correlation between the quality of the therapeutic alliance and treatment benefits. However, the strength of the correlation has generally been low to moderate and varies considerably across studies depending on a number of variables, including how the alliance is measured (Horvath et al., 2011). In particular, the correlation appears stronger in studies that assess the alliance using multiple rather than single measures (Crits-Cristoph et al., 2011).

Efforts to identify the mechanism through which the therapeutic alliance may have its effects suggests that formation of that alliance with the therapist might help clients improve their relationships with other important people in their lives. This, in turn, could result in symptom reduction (Coyne et al., 2019). There is speculation, too that the alliance might operate through neurobiological mechanisms, such as by activating "mirror neurons" in the brain that facilitate imitation. Activation of those neuron systems could make it easier for clients to emulate their therapists' supportive communication styles. A strong therapeutic alliance might even stimulate secretion of hormones such as oxytocin that tend to promote trust and social closeness (Zilcha-Mano et al., 2018). The exact mechanisms are still unclear.

We are also still unsure whether formation of a strong therapeutic

alliance is a cause or a consequence of clients' improvement. Some research suggests that the alliance comes first and helps to drive positive outcomes (Zilcha-Mano et al., 2014), whereas other studies appear to show that the strength of the alliance is a byproduct of effective treatment. For instance, a study of cognitive behavior therapy for eating disorders found that symptom reduction during the early phases of treatment—not the strength of the early therapeutic alliance—was the best predictor of additional progress (Turner, Bryant, & Marshall, 2015). Evidence that the therapeutic alliance can be both a cause and an effect of treatment outcomes can be seen in a meta-analysis of 20 studies on psychotherapy for eating disorders; it found that early symptom improvement was related to subsequent alliance quality and that alliance ratings were also related to subsequent symptom reduction (Graves et al., 2017).

The direction of the relationship between alliance and outcome in any given case might depend partly on client characteristics. It has been suggested that when some clients enter treatment, they already have the ability to form productive relationships with others, including the therapist, whereas others develop that ability only after interacting with the therapist (Zilcha-Mano, 2017). If this is true, clients with relatively good relationship skills might improve as a result of an easily-formed alliance with the therapist. Clients with less of these skills might develop them over time, after symptom improvement has begun. The extent to which the alliance is a cause or a consequence of symptom reduction may also depend on the type of treatment involved. In client-centered therapy and other relationship-focused treatments, the strength of alliance may be a strong driver of symptom reduction; when treatments focus more on teaching specific cognitive and

behavior-change techniques, the strength of the alliance may be driven by the results of those techniques (Zilcha-Mano et al., 2016).

Analyzing the Therapeutic Alliance

Dr. Sigal Zilcha-Mano, head of the Psychotherapy Research Laboratory in the department of psychology at the University of Haifa, Israel, studies the processes of therapeutic change. Her work has been instrumental in determining the components of the therapeutic alliance that predict treatment outcome.

(Source: Supplied with permission of Dr. Sigal Zilcha-Mano.)

Promoting the Therapeutic Alliance. Regardless of their theoretical orientations and their reading of the research literature, most clinicians agree that treatment goes more smoothly when therapist and client perceive their

alliance to be strong (Coyne et al., 2018). A key question is how to promote the strength of that alliance. One suggestion for doing so is to match clients and therapists on demographic or other variables. The idea is that similarity between client and therapist on certain characteristics is likely to “jump start” the alliance by making both parties more comfortable with each other and more likely to agree on therapy tasks and goals. However, matching clients and therapists on broad demographic variables such as gender or age appears to have little if any effect on therapy outcomes. Matching on ethnicity appears to have benefits, but those benefits might be driven more by psychological and interpersonal factors associated with ethnicity rather than by ethnicity itself (Horst et al. 2012; Rosen et al., 2012). For example, therapists who share a certain ethnicity with clients may simply have greater knowledge of the social and interpersonal challenges faced by people of that ethnicity. In that case, multicultural competency—a learnable skill—rather than demographic similarity, may be what makes particular therapists effective (Chao, Steffen, & Heiby, 2012; see our discussion of this topic in Chapters 4 and 15).

Promising variables for facilitating the therapeutic alliance are discussed in a special issue of the *Journal of Clinical Psychology* (Norcross & Wampold, 2010), and in a special set of articles in the journal *Psychotherapy* (Norcross & Lambert, 2014). One such variable is matching the type of therapy to clients’ attitude toward therapy. A meta-analysis of 12 studies evaluating this strategy found that clients who showed greater readiness to change had better outcomes with more directive treatments such as cognitive behavior therapy, and that clients who were more ambivalent about treatment did better in nondirective treatments such as client-centered therapy (Beutler et al., 2011). Results like these can help therapists to keep in mind the

importance of clients' ambivalence or readiness to change when trying to build a therapeutic alliance.

Research has also identified more general factors that appear to promote strong therapeutic alliances (Lavik et al., 2018). From the client's point of view, these factors include: (a) perceiving the therapist as competent and warm; (b) feeling understood as a whole person; (c) feeling appreciated, tolerated, and supported; (d) gaining new strength and hope for the future; and (e) overcoming initial apprehension about psychotherapy. A complementary set of therapist factors include: (a) combining technical interventions with interpersonal warmth; (b) communicating a genuine desire to understand the client; (c) supporting the client's capacity to change; (d) creating a sense of safety; (e) paying attention to body language; and (f) providing helpful experiences during the first session.

Like other close relationships, even the strongest therapeutic relationship can have its ups and downs. Research has consistently shown that therapeutic alliances tend to follow a high-low-high pattern of growth over the course of treatment (Halfon et al., 2019; Maxwell et al., 2018). The factors listed above can create great optimism in both parties at the beginning of therapy, but as difficulties are encountered along the way, optimism can be undermined by frustration. Ideally, as obstacles are overcome and progress is made, the alliance re-strengthens. It is during these low periods that the alliance may be vulnerable to **rupture**, a deterioration in the relationship manifested by disagreement about treatment goals, reduced collaboration on therapeutic tasks, or a strain in the emotional bond between client and therapist.

Rupture
Deterioration of a therapy relationship signaled by disagreement about goals, reduced collaboration, and a strained emotional bond between client and therapist.

Clinicians must recognize this common pattern in the alliance and find ways to avoid or repair ruptures. Their ability to do so depends on some of the skills we described as common among effective therapists, namely self-awareness, self-regulation, and interpersonal sensitivity (Eubanks-Carter, Muran, & Safran, 2015; Zilcha-Mano et al., 2019). Employing the right strategies during a rupture of the alliance is especially important given that meta-analytic research has found a significant relation between rupture resolution and positive patient outcome (Eubanks, Muran, & Safran, 2018).

A final consideration: As they seek to build and maintain a therapeutic alliance, clinicians must be aware of research showing that their perception of the alliance may differ significantly from that of their client, and that it may be less accurate (Bachelor, 2011; Jennissen et al., 2019). As a result, it is important for therapists to validate their perceptions of the alliance by periodically assessing their clients' views of it (Decker et al., 2013). We discuss this and other topics related to the therapy relationship further in Chapter 7.

Settings for Psychotherapy

The settings for psychotherapy are most easily divided into two categories: *outpatient* and *inpatient*. The first includes therapists' offices, school counseling centers, spaces in community centers or church basements, or anywhere else that clients and therapists agree to meet. The second includes facilities such as hospitals, prisons, or residential treatment centers, where patients reside for days, months, or rarely, years.

Outpatient Settings. Therapists' offices are by far the most common setting for psychotherapy. The requirements for a therapist's office are minimal, but certain features are important. The first is privacy. Because of the emotional nature of therapy, clients have a right to expect that their communications with their therapist remain confidential. For this reason, most therapists see clients in rooms that are soundproof, or nearly so, and they arrange not to be interrupted by phone calls, texts, or other intrusions during therapy sessions. However, the consulting room should not be too isolated from other people. This is especially important for therapists who work with potentially aggressive clients, or clients whose problems might lead to false claims of inappropriate therapist behavior.

Seating arrangements should be comfortable and should place clients and therapists on approximately equal levels. Office décor is typically designed to be inviting, orderly, but relatively neutral. A study in which students viewed color photographs of therapists' offices found that softness (comfort) and order were the most important factors in affecting the students' expectations about the quality of care, the expertise of the therapist, and the likelihood of their choosing the therapist based only on their offices (Nasar &

Devlin, 2011). If the therapist works with children, the therapy space should have toys and furniture appropriate to the clients' ages. In short, office accommodations should be designed to promote the therapist's treatment goals.

Of course, not all therapy takes place in an office. Group therapy, for example, is often conducted in larger spaces in office buildings, hospitals, community centers, senior centers, churches, and the like. As with private offices, therapists try as much as possible to structure other treatment environments in a way that maximizes the likelihood of achieving therapeutic goals.

Providing a Welcoming Place

A psychotherapist's office should be set up to maximize client comfort. Its décor can reflect the clinician's taste, but should not be so exotic or expressive of the therapist's views or interests that it would make some clients feel unwelcome and thus interfere with formation of a therapeutic alliance.

(Source: Jose Luis Pelaez/Photodisc/Getty Images.)

Some forms of treatment take place in public settings. For instance, a therapist treating a client with panic disorder might accompany the client to a mall so that the client can practice anxiety management techniques learned in therapy. Similarly, therapists might ride an elevator with an elevator-phobic client to help the client recognize symptoms, become more aware of cognitions, or practice tolerating anxiety. Therapists may even take client groups on outings where they can practice social and other skills first learned in an office setting (see Chapter 9).

The advent of various digital technologies has created a number of “virtual” settings for the delivery of psychotherapy. Some of these involve synchronous communication in which clients and therapists interact in real time, but remotely, such as via telephone or streaming video (e.g., Skype or Zoom). Others involve asynchronous communication via email or text, in which there are short delays between responses. As described in more detail in Chapter 10, these and other forms of online therapy have become much more prevalent in practice and in training, and a great deal of research is being devoted to questions about their effectiveness and the ethical issues surrounding them (Harwood et al., 2011a; Miller, 2013a).

Inpatient Settings. Inpatient therapy occurs in public, private, and VA hospitals, residential rehabilitation and treatment centers, prisons, jails, and many other settings. The requirements for therapy in these settings are similar to those for inpatient settings—clients have a right to expect privacy and professional treatment. But there are important differences as well. For example, in hospitals, the most common inpatient setting, clinicians are likely to be seeing clients with severe problems such as schizophrenia or major depressive disorder. Further, because clinicians working in hospitals are often part of a treatment team that includes physicians, psychiatrists, social

workers, and other health professionals, they must coordinate plans for their psychotherapy interventions with other treatments, such as medication, physical therapy, or psychosocial rehabilitation.

In Review The Participants in Psychotherapy

Clients	**Important factors in therapy:** Lack of access to treatment. Nature of their problems. Motivation for, or ambivalence about, treatment. Autonomy (freedom to make choices).
Therapists	**Important characteristics for therapy:** *Inter*personal skills (communication, self-monitoring, and relationship-building). *Intra*personal skills (secure attachment, coping ability, self-management, self-awareness, positive attitude).
Challenges for therapists	**Examples:** Concerns about one’s competency. Concern about one’s personality impairing effectiveness. Concerns about one’s working situation.
Client–therapist relationship (therapeutic alliance)	**Characteristics and influential factors:** Quality is related to treatment outcomes. Strength can rise, fall, and rupture over time. Promoted by therapist’s genuineness, empathy, unconditional positive regard, encouragement and sharing of the client’s goals. Alliance can be a cause or an effect of symptom improvement; exact mechanisms of influence are still unclear.
Treatment settings	**Types and characteristics**

	Outpatient (most common). Offices, schools, and other community locations. Ideally, create a sense of privacy and comfort. *Remote virtual.* Treatment conducted remotely using digital technology. Special ethical issues arise. *Inpatient.* Hospitals, prisons, and other residential facilities. Clinicians usually working on a treatment team.

Test Yourself

1. The ______________describes the emotional bond that develops between the therapist and client.

2. Carl Rogers emphasized the importance of three main therapist characteristics, including __________, ___________and ________________.

3. Psychodynamic clinical training programs typically require trainees to ________in order to become more effective therapists.

You can find the answers in the Answer Key at the end of the book.

The Goals of Clinical Interventions

Section Preview The various approaches to psychotherapy differ in several ways, but they share common therapeutic goals, including: (a) building a strong therapeutic relationship, (b) fostering insight, (c) providing new information (education), (d) assigning therapeutic tasks (homework), and (e) developing faith, hope, and expectations for change.

Different approaches to psychotherapy offer differing views of personality, personality development, and the causes of psychological disorders. Their treatment methods differ, too. Behavior and cognitive behavior therapists, for example, deal directly with the problem the client initially describes (along with other difficulties that might contribute to the primary complaint). So a mother who reports depression and social isolation and fears that she will harm her children might be encouraged to re-evaluate her self-critical thoughts, to purposely focus on her intrusive thoughts about harm, and to carry out a variety of "homework assignments" involving new social activities. By contrast, a psychoanalyst would explore the presumed underlying causes of the mother's depression; therapy might be aimed at helping the woman understand how her current symptoms relate to feelings of inadequacy as a mother because of failure to meet her own mother's rigid and unrealistic standards (Cohen et al., 2011). A humanistic therapist might deal with the problem by helping the mother discover her potential for creating alternatives that would free her from the one-dimensional life in which she now feels trapped. Despite these differences, most forms of clinical intervention are, to varying degrees, aimed at achieving a small set of

common goals, including building a strong therapeutic relationship, enhancing clients’ understanding of their problems, providing educational information, using “homework” tasks to promote progress, and increasing clients’ faith, hope, and expectations for improvement.

Building a Strong Therapeutic Relationship

A central method for helping clients feel comfortable engaging in therapy and being open about their problems is to build and make use of the budding therapeutic relationship. Clients tend to gain emotional stability and renewed confidence when they sense that the therapist is a personal ally, a buffer against the onslaughts of a hostile world. Some therapists offer direct reassurances such as “I know things seem hopeless right now, but I think you will be able to make some important changes in your life.” In other words, the therapeutic alliance can help by providing a safe, collaborative, and supportive atmosphere (Sullivan, Skovholt, & Jennings, 2005). More specific techniques, such as progressive relaxation training and cognitive restructuring can also serve to reduce client discomfort (e.g., Hazlett-Stevens & Bernstein, 2020).

Fostering Insight

In psychotherapy, having **insight** is typically defined as a client's understanding of the associations between past and present experiences, typical relationship patterns, and the ways in which interpersonal challenges, emotional experience, and psychological symptoms are linked (Jennissen et al., 2018).

> **Insight**
> Clients' awareness and understanding of the nature, causes, and factors maintaining their problems.

Insight was a chief objective for Sigmund Freud, who described it as "reeducation in overcoming internal resistances" (Freud, 1904, p. 73). He was interested in a particular type of insight, namely into unconscious influences, but most therapists today seek to promote a more general insight in the form of greater self-knowledge. Clinicians expect that, once clients better understand the factors that maintain their unhelpful behaviors, it will be easier for them to develop more adaptive behavior patterns (Høglend & Hagtvet, 2019).

Therapists of differing theoretical persuasions use varying methods to promote clients' self-examination and self-knowledge. Some psychodynamically oriented clinicians focus on a specific type of psychological content, such as dreams. Others encourage insight by asking

clients to examine the meaning of certain behaviors (e.g., “What relationship do you see between your conflicts with your boss and the anger you feel toward your dad?”). Cognitive therapists help clients become more aware of the automatic and maladaptive ways in which they explain events, particularly negative ones. Behavioral therapists stress the importance of helping the client understand how behavior is functionally related to past learning and current environmental factors. This functional analysis examines the triggers for unhelpful behaviors and the short- and long-term consequences of those behaviors.

A common therapeutic technique for developing insight is to *interpret* what clients say and do. The purpose of **interpretation** is not to convince clients that the therapist is right about the significance of some comment or event, but rather to motivate them to carefully examine their thoughts and behavior so as to draw new and more informed conclusions about them. Different theoretical approaches use differing terms for interpretation-related concepts (e.g., offering complex reflections in motivational interviewing or guided discovery in cognitive restructuring), but they all share an interest in illuminating the patterns that appear in a client’s thoughts, feelings, behaviors, or relationships. Whatever one calls it, interpretation must be used with a certain amount of sensitivity. Interpretations that are too dramatic, confrontational, or challenging can potentially stall progress and damage the therapeutic alliance (Strupp, 1989), but clients benefit when therapists use interpretation to point out, for example, connections between their behavior during treatment sessions and their relationships outside of therapy (Jones, Cumming, & Horowitz, 1988).

Interpretation

Therapist comments designed to prompt clients to examine their thoughts and actions and reach more informed conclusions about them.

Whatever the specifics, fostering client insight sets the stage for client and therapist to more directly and realistically address and more effectively resolve the client's problems (Lehmann et al., 2015). The consistency of the link between better insight and better treatment outcomes is supported by a meta-analysis of 22 studies. The link appeared regardless of the nature of clients' problems or the type of treatment that was used (Jennissen et al., 2018). One size does not fit all, however. Some research shows that higher levels of client insight are associated with more directive forms of therapy than with nondirective ones (McAleavey & Castonguay, 2014). And when dealing with some disorders, such as schizophrenia, promoting insight may require the use of special interventions such as metacognitive training to help clients learn how to examine their own thoughts and feelings (Lam et al., 2015).

Providing New Information (Education)

Though most people don't realize it, psychotherapy is often an educational process. Promoting insight is part of that process; it provides new ways for clients to understand how their disorders developed, are maintained, and can be overcome. And when clients' problems are traceable in part to misinformation about things like sexual functioning, therapist-educators can provide information to help alleviate those problems. Part of a therapist's skill as an educator is knowing how to present information in ways the client can understand. They may offer direct advice and information to their clients, or as described in Chapter 10, may suggest problem-related material for clients to read, a process known as *bibliotherapy* that meta-analysis has shown to be helpful in solving certain problems—even without seeing a therapist (Marx et al., 1992; Yuan et al., 2018).

Whatever the method of transmission, having new information gives clients an added perspective on their problems that can make those problems seem less unusual as well as more solvable.

Assigning Extratherapy Tasks (Homework)

Therapists of all theoretical stripes often ask clients to perform tasks outside of therapy for the purpose of encouraging the transfer of positive changes to the “real world” (Ronan & Kazantzis, 2006). Homework is typically designed to remind clients of important points from therapy sessions that might otherwise be forgotten and to encourage them to practice newly learned behaviors (Beck, 2011). Behavioral and cognitive behavioral therapists have always been advocates of homework assignments, believing them to be an effective way to promote the generalization of new skills learned in the therapist’s office (Kazantzis, Daniel, & Simos, 2009).

Practicing Relaxation Training at Home

A meta-analysis of cognitive behavior therapy studies found that the quantity and quality of homework was positively correlated with treatment outcome for at least a year after therapy ended (Kazantzis et al., 2016). Studies of homework assignments in psychodynamic and humanistic therapy also support the value of these assignments (Burns & Spangler, 2000; Ronan & Kazantzis, 2006).

(Source: Heide Benser/The Image Bank/Getty Images.)

Developing Faith, Hope, and Expectations for Change

Of all the goals common to all systems of therapy, raising clients' faith, hope, and expectations for change is the goal most frequently mentioned by therapists as a crucial contributor to clients' improvement. This view is supported by a meta-analysis of 81 studies of 12,722 clients; it found a significant association between more optimistic expectancies before treatment and more adaptive outcomes afterward (Constantino et al., 2018).

The mechanism through which positive expectancies appear to support better outcomes is unclear. Clients with higher expectations may be more likely to complete homework assignments and/or to more easily form a productive therapeutic alliance. Positive expectations may also lead to greater willingness to engage in challenging but helpful aspects of treatment, whether it be exposure to feared situations in cognitive behavior therapy or facing interpretations in psychodynamic therapy (Chambless et al., 2017). Or perhaps the mechanism is less specific and dates back to long before the first therapist saw the first client.

After all, the curative power of positive expectations is not restricted to psychotherapy. It has been said, for example, that the early history of medical treatment is largely the history of the **placebo effect**, through which treatments that contain nothing known to be helpful still produce benefits because clients believe they will do so (Foroughi et al., 2016; Howe, Goyer, & Crum, 2017; Shapiro, 1971). Some therapy techniques may be particularly potent in raising expectations and creating placebo effects because they appear dramatic or high-tech, or because they tap into ingrained cultural norms associated with the best ways to achieve personal change. Indeed,

clinicians are so accustomed to thinking about the placebo effect in psychotherapy that many attribute much of psychotherapy's success to that effect rather than to specific treatment techniques.

Placebo effect

The appearance of treatment benefits based on clients' belief that the treatment will help.

Still, recognizing the role of placebo effects in psychotherapy does not eliminate the importance of specific techniques, nor does it negate the need to understand how specific techniques work. It does mean, however, that one important element of many effective therapies is that they cause clients to believe that positive changes are possible (Constantino et al., 2011; Orlinsky, Grawe, & Parks, 1994). Many clients begin psychotherapy expecting to engage in a unique, powerful experience conducted by an expert who can work miracles. The perceived potency of psychotherapy is further enhanced for clients who enter it after having fretted for a long time about whether they really need treatment. By the time this internal debate is resolved, these clients have a large emotional investment in making the most of a treatment that is regarded with a mixture of fear, hope, and relief.

For their part, therapists encourage clients' faith in the power of psychotherapy by providing assurance that they understand the problem and that, with hard work and commitment by both partners in the therapeutic relationship, desired changes are possible. As mentioned earlier, some

therapists may provide direct reassurance early in treatment that the client's problems can be addressed successfully. The client's perception that "I have been heard and understood and can be helped" can be as important as the soothing effect that physicians create by displaying calm confidence in the face of a patient's mysterious physical symptoms. Most therapists bolster this perception by offering a theory-based *rationale* for why treatment will be effective.

Therapists also try to further elevate clients' motivation and expectations for success by promoting some early success experiences. These first successes might be minor—a limited insight after a simple interpretation by the therapist or the successful completion of a not-too-difficult homework assignment—but the cumulative impact of many small changes in the initial stages of therapy helps to reinforce clients' confidence that they can control their lives and that their problems are understandable and solvable. As more positive expectancies are confirmed, clients' belief in the possibility of meaningful changes increases. They then pursue those changes with even greater determination, which in turn makes further success more likely (Howard et al., 1993). All the while, the therapist enhances the client's self-efficacy by pointing out that the changes are the result of the client's own efforts (Bandura, 1982).

In Review The Goals of Clinical Interventions

Goal	**Therapist Activity**
Building a strong therapeutic relationship	Provide a safe, collaborative, and supportive atmosphere in which clients can feel comfortable about engaging in treatment.
Fostering insight	Promote self-examination and self-knowledge.
Providing new information (education)	Counter misconceptions, explain how problems can arise, be maintained, and alleviated. Suggest helpful reading material (bibliotherapy) or other resources.
Extratherapy assignments (homework)	Remind clients of important points from therapy sessions that might be forgotten and encourage them to practice newly learned behaviors at home.
Developing expectations for change	Present a theory-based rationale for treatment. Promote early success experiences.

Test Yourself

1. For Freud, insight meant understanding the role of _______ processes in disorder. In behavioral and other forms of treatment, insight is about more general _________.

2. Educating clients requires that the therapist be able to present information at what level?

3. The positive expectations that help clients succeed in psychotherapy are related to the _________, a phenomenon long recognized as part of the

success of medical treatment.

You can find the answers in the Answer Key at the end of the book.

Ethical Guidelines for Clinical Interventions

Section Preview Ethical guidelines help define and shape the therapeutic relationship. The primary guidelines for psychologists come from the APA's Ethics Code. The APA also offers a number of other guidelines in publications designed to help practitioners who deal with more specialized situations and client populations.

The practice of psychotherapy is shaped by the therapist's commitment to ethical and professional guidelines that protect clients and insulate the relationship from the negative influence of outside forces. But ethical guidelines do much more than that. Ethical principles guide the clinician's day-to-day and even moment-to-moment decision-making (Nagy, 2011; Sperry, 2007). For example, consider the following examples:

- A depressed client calls a therapist at home and asks for an emergency therapy session that evening. Should she grant the request?
- A 14-year-old client reports that her father occasionally strikes her 12-year-old brother and her mother, but she implores the therapist not to say anything about this information during their next family therapy session. Should the therapist comply with the client's wish?

The APA Ethics Code

In deciding how to handle situations like these, clinical psychologists are guided by the American Psychological Association's *Ethical Principles of Psychologists and Code of Conduct* (American Psychological Association, 2017a). As its name suggests, this document consists of two main sections: (a) General Principles and (b) Ethical Standards. The five General Principles are beneficence and nonmaleficence, fidelity and responsibility, integrity, justice, and respect for people's rights and dignity. Each of the ten Ethical Standards is divided into sections and subsections, resulting in a total of 151 ethical rules for psychologists (see Chapter 15 for more details). Section 10 covers psychotherapy and has subsections on issues such as informed consent, therapy involving couples or families, sexual intimacies with clients, and so on (see Table 6.2).

Table 6.2 Examples of Ethical Dilemmas That Therapists May Face

Situation Raising Ethical Concerns	Applicable Sections of the APA Ethics Code
During therapy, a client says that he has been thinking about killing his girlfriend.	4.01 Maintaining confidentiality 4.02 Discussing the limits of confidentiality
A client who tested positive for HIV reveals to his therapist that he continues to have unprotected sex.	4.01 Maintaining confidentiality 4.02 Discussing the limits of confidentiality
During group therapy, a therapist learns that a group member has broken	10.03 Group therapy

confidentiality by talking to friends about other group members.	
A court has ordered a client to obtain treatment or face jail time, so the client enters treatment but is unwilling to commit to or invest in it.	3.07 Third-party requests for services
A therapist who has been treating a married couple is now called upon to be a witness for one party in a divorce proceeding.	10.02 Therapy involving couples or families
A therapist would like to present the case of a client at a seminar, but the client wants to remain anonymous.	4.07 Use of confidential information for didactic or other purposes
A therapist considers becoming romantically involved with the ex-husband of a client.	10.06 Sexual intimacies with relatives or significant others of current therapy clients/patients
A therapist learns that a colleague has been using a controversial therapy that research suggests may produce more harm than good.	1.05 Reporting ethical violations 2.04 Bases for scientific and professional judgments

Four areas of the APA Code have particular relevance for psychotherapists. They include confidentiality, competency, informed consent, and conflict of interest.

Confidentiality. Ethical therapists protect the client's privacy and, except under specific circumstances, do not reveal information that the client shares in therapy. Those special circumstances are described in Chapter 15.

Protecting confidentiality obligates clinicians to regard the welfare of their clients as their main priority. With very few exceptions, the therapist's commitment must be directed by a singular concern: *What is best for my client?*

Competency. Competent clinicians are professionally responsible, meaning that they practice only within their areas of expertise. They maintain high standards of scientific and professional knowledge. Competence is difficult to measure, but it is based on a combination of education, training, experience, and credentialing. In practice, it means that clinicians will not engage in assessment or therapeutic practices unless they have had the appropriate education, training, and/or supervised experience needed for those practices, nor will they conduct therapy with demographically diverse populations if they do not have the cultural competency to do so. Competency is probably better thought of as a developmental process than an either–or condition (i.e., competent or not competent). The competency requirement protects consumers from blatant malpractice, but it is also designed to motivate clinicians to engage in career-long training and education.

Informed Consent. Therapists are obligated to tell clients about the limits of confidentiality, about potential outcomes of treatment, and about anything else that might affect the clients' willingness to enter therapy. For instance, therapists conducting couples therapy typically inform clients that one possible outcome of the therapy is that the couple could decide to separate or divorce.

Conflict of Interest. Therapists are obligated to maintain therapeutic boundaries, also known as a therapeutic "framework," which establishes for the client a set of expectations about the roles and interaction patterns that

will occur within the therapeutic relationship. A conflict of interest would occur if the therapist's personal interests compete with the best interests of the client. Such conflicts might be minor, as when a therapist must decide whether venting his frustration at a client during a session is good for the client or simply self-indulgent. But conflicts of interest can also be more serious, such as when a therapist contemplates a sexual relationship with a client or a former client.

The Ethics Code guides practitioners as to what they should or should not do, but as described in Chapter 15, it cannot cover every situation that clinicians might face. Supplemental guidance is provided by books on ethical clinical practice (e.g., Nagy, 2010; Pope & Vasquez, 2016; Sperry, 2007) and by additional guidelines on the APA website for clinicians working in specific areas of practice. These include APA guidelines for Child Custody Evaluations in Divorce Proceedings, Psychological Practice with Older Adults, Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations, Psychotherapy with Lesbian, Gay, and Bisexual Clients, and Psychological Practice in Health-Care Delivery Systems, as well as Specialty Guidelines for Forensic Psychology, and a Statement on Services by Telephone, Teleconferencing, and Internet.

Ethics and the Therapist's Values

When clients struggle with value-related problems, therapists struggle as well, particularly if the therapist holds values that are different from those of the client. In fact, it is safe to say that at some point in their careers, all therapists are sure to have their cherished values challenged (see Table 6.3). Some challenges will be relatively minor, such as when trying to decide whether to try convincing a teenage, court-referred client that watching professional wrestling may not be the most important thing he can do with his life. Others are much tougher, such as when a depressed client with terminal cancer is contemplating suicide; should the therapist try to convince her not to kill herself?

Table 6.3 Value-Laden Topics That Can Arise During Psychotherapy
Here are just a few of the value-laden topics that can come up in therapy. There is no clear formula for deciding how to handle values conflicts in psychotherapy; ethical guidelines can help, but every situation is different, so therapists must ultimately reach their own conclusions.

abortion	animal rights	assisted suicide
birth control choices	career choices	child abuse and neglect
criminal activity	death and dying	dietary choices
domestic violence	gang membership	gender roles
health-care choices	marriage and cohabitation	medical ethics

politics	premarital sex	racism and sexism
religious beliefs	religious practices	sexual orientation
sexual practices	substance abuse	environmental practices
suicide	use of power in relationships	weight and weight loss

Source: Based on Brems, C. (2001). *Basic skills in psychotherapy and counseling* (p. 46). Belmont, CA: Wadsworth.

Certainly, the Ethics Code applies, but exactly how it does so may not be obvious in every case. This is an example of the importance of therapist self-awareness. When confronted with values conflicts, therapists must recognize their own values and how those values might influence treatment, and then bite the bullet and make a decision. Should they set aside their values and follow the client's lead? Reveal the values that conflict with the client's? Try to change the client's values or perhaps try to change their own? Stop working with the client? Or try to find some other option? Most therapists find it very helpful to discuss the therapeutic and personal implications of values conflicts with supervisors or colleagues (while taking appropriate measures to protect client confidentiality) to help make sure they are considering the situation from all angles.

In Review Ethical Guidelines for Clinical Interventions

Sources of Ethical Guidance	**Features**
APA Ethical Principles of Psychologists and Code of Conduct APA specialty guidelines	Current edition includes five general principles and ten ethical standards whose subsections contain 151 rules. Relate to child custody, older adults, diverse populations, LGBTQ+ clients, health-care practice, forensic practice, and use of technology, among others.
Main Ethical Concern for Psychotherapists	**Description**
Confidentiality	Therapists protect the client's privacy and, except in specific circumstances, do not reveal information shared in therapy.
Competency	Therapists practice only within their areas of expertise and training.
Informed consent	Therapists tell clients about the limits of confidentiality, about potential outcomes of treatment, and other factors that might affect their willingness to enter treatment.
Conflict of interest	Therapists must ensure that their clients' interests are prioritized.

Test Yourself

1. A therapist is contemplating selling his house to a client. Actually doing so would create a _________________ for the therapist.

2. Therapists should consult with _________or __________ when unsure how to handle an ethically tricky situation.

3. One of the most difficult ethical situations arises when therapists are working with clients whose ______ differ significantly from their own.

You can find the answers in the Answer Key at the end of the book.

Some Practical Aspects of Clinical Intervention

Section Preview Here we address some practical questions and procedures common to all forms of psychotherapy. These include treatment duration, fees, record keeping, treatment planning, therapist self-disclosure, and termination. We conclude with discussion of current trends in clinical intervention.

People who are considering psychological treatment often ask some practical questions about psychotherapy: How long is it going to last? How much will it cost? What records will my therapist keep? How much can I learn about my therapist as a person? How will my therapist decide what kind of treatment to use? Let’s consider each of these questions now.

Treatment Duration and Fees

The duration of treatment can range from one day to several years, depending on the type and severity of the client's problems; the strength of the client's motivation to change; the skill and orientation of the therapist; and the client's financial resources. Traditional psychoanalytic treatment can last for years, during which clients are seen for several hour-long sessions each week. That pattern is relatively rare today; most clients in individual psychotherapy are seen for about an hour each week (group therapy sessions typically last 90 to 120 minutes). Evidence from managed-care insurance claims suggests that the average treatment length is about 7 or 8 sessions, but that figure can vary considerably by region and by the client's diagnosis (Crane & Payne, 2011). Longer treatments are not necessarily more effective overall (Schmidt et al., 2018; Stiles, Barkham, & Wheeler, 2017), but for disorders such as depression, more sessions tend to yield better outcomes (e.g., Cuijpers et al., 2013a).

Clinical psychologists' single-session fees vary substantially, so it is difficult to provide an overall summary. A variety of factors, including location (e.g., rural versus urban), clinicians' level of training, funding sources (e.g., private pay versus insurance), and type of disorder, can all affect fees. Further, psychologists or their employing agencies often provide free service or reduced payments on a sliding scale for clients with various levels of financial need. Providers might also accept lower payments from insurance companies who set reimbursement limits for particular services. Mental health clinics and private practitioners post their services and fee

structures online, so it is easy for potential clients to anticipate costs before committing themselves to treatment.

Record Keeping

The *APA Record Keeping Guidelines* (American Psychological Association, 2007a) obligate ethical psychotherapists to keep good records of their services to clients. These are guidelines, meaning that they do not mandate exactly what records must be kept, but they describe the basic content of records, how the records should be controlled, how long they should be retained, and how and when and to whom it is ethical to disclose them. Psychologists should keep records of: (a) their clients' identifying information, (b) dates and types of service, (c) fees, (d) assessment results, (e) treatment plans, and (f) consultations with others about clients. These records should be presented at a level of detail that would allow another clinician to take over the case should circumstances require it. In short, good record keeping is designed to benefit clients, clinicians, and their institutions. Good records can also be valuable if clinicians are involved in legal proceedings, and reviewing records, especially records of effectiveness, can motivate clinicians to find ways to improve their services.

Case Formulation and Treatment Planning

In Chapter 3, we present a general model for assessment which begins when the clinician receives and clarifies the referral question and ends with a report that communicates assessment results (see Figure 3.1). Psychotherapy also begins with assessment, though it might not involve formal procedures such as structured interviews or psychological tests. It does, however, lead to a **case formulation**, (also called a **case study guide**) the clinician's conceptualization of the client's problems, strengths, and protective factors, including hypotheses about the processes that have caused and maintained the client's distress. These hypotheses guide the therapist's clinical decisions, especially about which treatment methods will be most appropriate and how the effectiveness of those methods will be evaluated during the course of treatment (Persons, Beckner, & Tompkins, 2013). In short, treatment planning depends on case formulation, which in turn depends on assessment.

Case formulation (case study guide)
A clinician's conceptualization of the client's problems, strengths, and protective factors, along with their interconnections, origins, and the factors that maintain problems.

Three Approaches to Treatment Planning. Three main approaches to treatment planning have dominated the scene over the history of clinical psychology (Makover, 2004). The first, and oldest, is called *therapist-based*

treatment planning, also known as *top-down* planning because it reflects the high-level influence of the therapist's preferred theoretical orientation. In this approach, therapists treat all clients using methods suggested by that orientation (e.g., psychodynamic, behavioral, humanistic, or whatever).

Over time, as many clinicians and researchers became disenchanted with this "one-size-fits-all" approach to treatment planning, they began to adopt an approach in which the client's diagnosis, not just the therapist's orientation, shapes treatment decisions. Modeled after medical treatment selection, this *diagnosis-based* approach to treatment planning takes into account what empirical research says is most likely to be helpful for each general diagnostic category of disorder (see our discussion of empirically supported treatments in Chapter 7). Most clinicians view diagnosis-based treatment selection as more scientific than the therapist-based approach, but it is based on a less than perfect diagnostic system (see Chapter 3). Further, as mentioned earlier in this chapter, a great deal of research has shown that factors other than a diagnosis—such as clients' individual characteristics and the quality of the therapeutic alliance—are also responsible for significant variations in treatment outcomes.

So in accordance with the standards of *evidence-based practice* described in Chapter 1, the intervention choices made by clinical psychological scientists today are influenced by a combination of their theoretical orientations, the results of empirical outcome research, and what they learn about each client's values, goals, and preferences. This approach has been called *outcome-based* because it attempts to base treatment planning on many of the most important factors that can affect treatment outcome. It allows clinicians to use *top-down* (theoretical) and *bottom-up* (client-specific) factors and data to create treatment plans that are tailored to the individual

needs of each client (Dudley, Ingham, Sowerby, & Freeston, 2015; Gazzillo, Dimaggio, & Curtis, 2019). The value of the outcome-based approach is supported by numerous clinical trials in which treatment was successful in terms of meeting clients' personalized goals even if it did not result in reduced scores on symptom checklists (Lindhiem et al., 2016).

The outcome-based approach to treatment planning appeared as early as 1973, when Arnold Lazarus suggested that clinicians should gather a range of information about a client when designing interventions. His approach, called BASIC-ID (Lazarus, 1973), encouraged clinicians to design treatments based on assessment of clients' Behaviors, Affects, Sensory experiences, Imagery, Cognitions, Interpersonal relationships, and need for Drugs. An increasing number of investigators are working on treatment planning approaches, some of which conform to a particular theoretical approach and some of which attempt to be theory-neutral. One notable example is *Systematic Treatment Selection* (STS; Beutler & Clarkin, 1990; Beutler, Williams, & Norcross, 2008; Harwood, Beutler, Williams, & Stegman, 2011), which aims to identify specific client characteristics that research tells us are most likely to affect therapy outcomes and then to match these with specific forms of treatment. The information needed to conduct STS comes from the usual clinical assessment sources, namely interviews, observations, archival records, and tests (see Table 6.4). The STS approach shows considerable promise (Beutler et al., 2016).

Table 6.4 Information Sought in Systematic Treatment Selection

Here are examples of the clinical information that goes into the STS approach to treatment planning. Using a web-based program, therapists and clients can

enter key information that can help select the most promising forms of treatment for the clients' problems.

Client Characteristics	Potential Treatment Dimensions
Level of functional impairment	High versus low treatment intensity
Level of social support	Treatment modality
Problem complexity	Treatment format
Coping style	Skill-building and symptom focus versus insight- and awareness-focused interventions
Level of trait-like resistance	High versus low therapist directiveness
Level of subjective distress	Relative level of emotional experiencing

Source: Harwood, T. M., Beutler, L. E., Williams, O. B., & Stegman, R. S. (2011). Identifying treatment-relevant assessment: Systematic treatment selection/InnerLife. In T. M. Harwood, L. E. Beutler, & G. Groth-Marnat (Eds.), *Integrative assessment of adult personality* (pp. 61–79). New York, NY: Guilford.

These personalized approaches to treatment planning emphasize client choice and shared decision making. The therapist and client discuss research evidence about what treatment methods have been shown to be helpful on average for a given problem and consider how well that evidence and those methods fit the client's needs and preferences (DeRubeis, 2019). As many

clients enter treatment with a complex mix of problems, this kind of treatment planning can also help determine which problems to address first (see Woody et al., 2002).

Therapist Objectivity and Self-Disclosure

Clients are expected to disclose a great deal of personal information—indeed, therapy would be impossible without it—but what about therapists? In many instances, therapists must decide whether to share personal information such as their emotional reactions, incidents from their own lives, and the like. Such sharing is called *therapist self-disclosure*, but how far should it go? Should a therapist reveal feelings of irritation or boredom during a session? Should a therapist reveal that she is divorcing or mourning a recent death in her family? Should a therapist discuss his former addiction or his own experience as a therapy client?

The fact is that there are potential benefits and risks in both disclosure and nondisclosure. Therapists who never self-disclose risk being perceived as cold and aloof, which might impair the therapeutic relationship. Therapists who frequently self-disclose risk being perceived as impulsive, self-absorbed, or compromising the professional nature of the client–therapist relationship. They may also be perceived as too imposing (Ziv-Beiman & Shahar, 2016). If disclosure is too emotionally intense, it can be countertherapeutic (Berg, Antonsen, & Bider, 2016), but appropriate therapist self-disclosure is associated with enhanced therapy relationships and improved client functioning (Hill, Knox, & Pinto-Coelho, 2018). The big question, though, is what is "appropriate" and what isn't?

There are no firm rules, and practices vary across therapists and theoretical orientations. Traditional psychoanalytic therapists have advocated strict prohibitions against disclosing personal information—they insist that the focus should always be on the client and the client's problems. Modern

psychodynamically oriented clinicians recognize that utter nondisclosure is an impossible ideal because therapists are always revealing something about themselves in their verbal and nonverbal behavior (Gabbard, 2014; Ramseyer & Tschacher, 2011). Accordingly, a minimal amount of self-disclosure is accepted. Cognitive behavior therapists also tend toward lower levels of self-disclosure (Hansen, 2008). At the other extreme are eclectic and humanistically-oriented therapists who favor considerable therapist disclosure; they view it as part of communicating warmth and genuineness. Therapists from other orientations fall somewhere in the middle of the acceptability of self-disclosure dimension.

Disclosure decisions can also be affected by ethical considerations. Therapists must ask themselves (and sometimes make split-second decisions about) whether a disclosure is in the client's best interest. The closeness and intensity of the therapeutic relationship may tempt the therapist to discard professional restraint in favor of spontaneous reactions, including pity, frustration, hostility, attraction, or boredom. Therefore, therapists must stay alert to these "boundary challenges" (Frankel, Holland, & Currier, 2012) and monitor the ways in which their personal needs might intrude upon therapy. The question that always applies is: Whose needs are most being served by a therapist's disclosure?

Termination

All forms of therapy eventually end (Hilsenroth, 2017), and in most cases, this happens when the treatment process has been completed and the therapist and client agree that most or all of their goals have been achieved. This is a time for the therapist to highlight and express pride in the client's progress, to remind the client to use newly learned skills in the wider world, and to frame the client's personal development as a continuing process in which, with continuing effort, there will be even further growth (Norcross, Zimmerman, Greenberg, & Swift, 2017). Together, client and therapist can reflect with pleasure on the success of their shared efforts, and the client, especially, can enjoy having a greater sense of independence and growth. True, each is likely to experience some mixed feelings at this point, including the sense of loss that comes at the end of a meaningful relationship (Roe et al., 2006), but the termination of successful treatment is typically a positive experience for both parties (Goode et al., 2017).

According to some estimates, however, as many as 20% of adult clients terminate psychotherapy prematurely, that is, before the treatment process has been completed (Swift & Greenberg, 2015; Swift et al., 2017). **Premature termination** is a significant yet often neglected problem in psychotherapy that can have negative consequences, including the return of problems that had been only partially resolved. Some evidence suggests that the clients most likely to terminate prematurely are those who experienced dramatic improvements in well-being early in treatment (Kivlighan et al., 2019). Much like medical patients who stop taking antibiotics when they start to feel better, but before their infection has been eradicated, these clients may

misinterpret their early therapy gains as evidence that no further treatment is necessary. Other factors associated with premature termination include mismatches or other client–therapist problems that interfere with creation of a productive therapeutic alliance (Olivera et al., 2017; Schoenherr et al., 2019), and logistical challenges tied to attending and paying for sessions. Several strategies have been suggested for reducing premature termination, including incorporating client preferences into the treatment decision-making process, continuously assessing and discussing the meaning of treatment progress (or lack of it), and doing everything possible to enhance clients' motivation for treatment and strengthen the therapeutic alliance.

Premature termination

Clients' leaving psychotherapy before the treatment process has been completed.

Two Broad Trends in Clinical Intervention

You have seen that the dominant mental health service model for many decades was individual psychotherapy in which a therapist interacts face-to-face with a client and administers a form of psychotherapy derived from a particular theoretical framework (e.g., psychodynamic, cognitive behavioral, humanistic). However, two major trends signal significant changes in the field.

The first of these can be seen in the shift mentioned earlier in which treatment selection is being based more on clinical utility (what works), than on the therapist's theoretical orientation alone. Instead of continuing to do battle over which *theories* generate the most effective treatments, clinical scientists are now dealing with more practical—and important—questions about which specific *treatments* work best for which clients with which problems in which environments (see our discussion of this vital question in Chapter 7). Focusing on utility helps make everyone more flexible, and, we hope, less ideologically rigid. Of course, broad theoretical orientations remain important as guides to training and practice, but placing greater emphasis on utility is a welcome trend because it can further unify the field and help to provide more effective treatments to an increasingly diverse client population (Silverman, 2013).

The second, and closely related, trend can be seen in the expansion of methods for delivering mental health services. It has become clear that the majority of people in developed and developing countries who need treatment for mental health problems are not receiving it. One of the main reasons for this treatment gap is that the standard delivery method

—individual therapy—and the number of professional therapists available to offer it, are unable to reach most of those in need. As a result, leaders in the field of global mental health are advocating alternative modes of service delivery. Thinking outside the individual psychotherapy box has led to expansion of existing options and creation of new ones. There is more group and family therapy, more emphasis on the prevention of mental disorders, and wider use of digital technology to deliver mental health services remotely via cell phones or the internet. There are also *task-shifting* programs in which professionals in medicine, nursing, and other health-related fields—as well as trained non-specialist providers (e.g., bartenders, hairdressers, neighbors, and teachers)—deliver specific kinds of mental health services, especially in countries or regions where the availability of professional services is particularly poor (Kazdin & Rabbitt, 2013). The expansion of service delivery beyond traditional therapy approaches is likely to create new roles for mental health professionals, help further erase the distinction between health care and mental health care, and provide ways to deliver mental health services to many more people. We describe the topic of mental health delivery in much more detail in Chapter 10.

In Review Some Practical Aspects of Clinical Intervention

Topics	**Key Points**
Treatment duration and fees	Treatment duration can range from one day to several years. Single-session fees can vary substantially, depending on location, type of therapist, insurance, and other factors.
Record keeping	Ethical standards require therapists to keep records of clients' identifying information, dates and types of service, fees, assessment results, treatment plans, and consultations with others.
Case formulation and treatment planning	Case study guides and treatment selection can be based on the therapist's theoretical orientation, on results of empirical research about which treatments work best for particular disorders, on clients' values, goals, and preferences, or a combination of all these factors.
Therapist objectivity and self-disclosure	There are potential benefits and risks associated with therapist self-disclosure and nondisclosure. The decision to self-disclose should be informed by what is best for the client.
Termination	Termination of successful treatment is typically a positive experience for both client and therapist. Premature termination can be problematic, but often also preventable.

Test Yourself

1. Longer treatment durations tend to be associated with ___________ approaches to treatment.

2. A treatment planning approach based mainly on the therapist’s theoretical orientation is called __________.

3. The therapists most likely to engage in a lot of self-disclosure tend to take a ___________ approach to treatment.

You can find the answers in the Answer Key at the end of the book.

Chapter Summary

Clinical intervention involves a deliberate attempt to make desirable changes in clients' behavior, thinking, emotional well-being, and social interactions. Treatment begins when a client in need of help is seen by a therapist with special training. Therapists can include professionals trained in clinical psychology, counseling psychology, psychiatry, psychiatric social work, psychiatric nursing, family counseling, or a variety of other paraprofessional and specialty areas.

The participants in psychotherapy—therapists and clients—bring individual strengths and weaknesses to the situation. Most clinicians agree that effective therapy is facilitated by the development of a supportive yet objective relationship, which in turn is fostered by certain therapist and client contributions. Effective therapists tend to have interpersonal skills in communication, relationship building, and self-monitoring. Characteristics described by Carl Rogers as genuineness, empathy, and unconditional positive regard are especially important in developing a strong therapeutic relationship. Client characteristics such as motivation and openness also contribute to the effectiveness of therapy, but therapy outcome is also associated with the strength of the therapeutic alliance—the bond between therapist and client and their agreement on therapy tasks and goals. It is likely that the therapeutic alliance can be both a cause of clients' improvement and a consequence of that improvement.

Psychotherapy is most often conducted in an individual format in an outpatient setting. However, it can also be conducted in other settings.

Approaches to psychotherapy can differ, but to varying degrees they all attempt to accomplish a common set of goals: building a strong therapeutic relationship, enhancing clients' understanding of their problems (insight), providing educational information, using "homework" tasks to promote progress, and increasing clients' faith, hope, and expectations for improvement.

Psychotherapy is guided by the APA Ethics Code. Standards most important to psychotherapy practice involve confidentiality, competency, informed consent, and conflict of interest. The Ethics Code is an invaluable aid in many areas of clinical decision-making, but there is a variety of other codes and guidelines that help clinicians to navigate ethically tricky problems in specialized areas of practice.

Psychological treatments involve a number of practical considerations: fees, decisions about the type and length of service, record keeping, and so on. Treatment planning is one of the most important of these practical considerations. Although treatment planning can be done in three main ways, we think that an outcome-based approach—which includes theoretical considerations, the results of empirical research and client-level data, and clients' values, goals, and preferences—is the most empirically and ethically defensible.

A certain amount of therapist self-disclosure can nurture the therapeutic relationship, but if too frequent or too intense, it can create problems.

Terminating successful treatment is usually a positive (though often bittersweet) experience for client and therapist. Preventing premature termination—caused by client–therapist relationship problems or over-optimism about early progress—is important if treatment is to succeed.

7

Research on Clinical Intervention

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Contents

Methods for Studying Psychological Treatments

Results of Research on Individual Treatments

Results of Research on Other Modes of Intervention

Issues and Concerns about Research on Psychotherapy

Chapter Preview

In the next three chapters, you can read about a wide range of psychotherapy methods. In this chapter, we describe the strengths and limitations of the methods that clinical scientists use to determine if and how those various therapies work. We highlight the latest research findings on the efficacy and effectiveness of established treatments as well as of alternative modes of intervention. Our major focus will be on evaluation of evidence about which psychological treatments are best for which clients with which problems, but we close with a discussion of research on the effects of psychoactive drugs in the treatment of psychological disorders.

A Clinical Case

You may remember from Chapter 1 that, as Rachel Jackson's mother, Lena, became more and more concerned about Rachel's dieting and poor grades, she confided in her Chinese American friend and coworker, Ellen Yang. Ellen's advice to seek professional help for Rachel was based largely on her own experience with the problems of her son, Eric. At the age of 26, Eric was living with his mother while attending graduate school in information technology. His studies were hampered, however, because he was experiencing major depressive disorder, generalized anxiety disorder, and anger problems.

Eric is the youngest and, according to him, the "least successful" of three children. His parents told him that he resulted from an unwanted pregnancy that was almost aborted. He experienced many

other stressors while growing up, including financial hardship and frequent fights between his parents that focused mainly on his father's gambling and his mother's tendency to hoard useless items. His two academically gifted sisters each graduated from prestigious universities, which made it all the more difficult when Eric was not accepted by any university. It was at that point, during his senior year in high school, that he experienced his first major depressive episode. He did manage to graduate, though, and to attend a local community college. He later transferred to a state university where he earned a degree in computer engineering. While Eric was in college, his father's gambling problem intensified to the point that the family's retail business was lost, and soon afterward, his parents divorced.

As Eric became increasingly depressed, he began to think about suicide. He had no specific plan, but he mentioned to a friend that he would kill himself if he could find a "fast, secure, and reliable" method for doing it. The friend pointed out the seriousness of these thoughts and pushed hard for Eric to talk to someone at the campus psychological clinic. When Eric finally did so, he was assigned to see Dr. Samantha Wang (not her real name), a recent graduate of the university's clinical psychology program. That assignment was made partly because, though Dr. Wang is not Chinese, she had not only taken the cultural competency course required by her clinical psychology training program, but she has been married to a Chinese American for 10 years and is thus more familiar than most other staff members with Chinese American culture and more aware of the research literature on cultural differences in the expression and treatment of depression.

At the first interview, Eric showed noticeably negative interpersonal behavior, such as rolling his eyes at the therapist, sneering at the idea of therapy, and making other sarcastic comments. Dr. Wang's clinical assessment of Eric's problems included the MMPI-2, the Beck Depression Inventory (see Chapter 5), and other personality tests. His scores on these tests were in the severe range of depression and in the moderate range of anxiety. The initial interview revealed that Eric slept poorly and was often angry, but also that he was honest, resilient, and a hard worker.

Eric saw Dr. Wang for 41 sessions over the course of a year. In addition to establishing a "commitment to treatment" contract (in which Eric promised not to commit suicide and to try therapy for a fixed period of time), she employed the methods of cognitive and cognitive behavioral therapies described in Chapter 9. For example, Eric repeatedly expressed self-defeating thoughts, such as "Remember to keep telling yourself that you are not good enough" and "Don't ever be satisfied with your accomplishments." These thoughts were consistent with his culture's values about humility and achievement, but in his case, also helped to fuel his depressive symptoms. Dr. Wang realized this, and used her knowledge of Eric's cultural background to help build rapport with him and help him re-evaluate his self-critical thinking and engage in more reinforcing activities. She also arranged for a psychiatrist to provide Eric with a prescription for antidepressant medication.

By the end of his work with Dr. Wang, Eric's depression, anxiety, and anger had all decreased significantly. His social skills had also improved somewhat, and he no longer had intrusive thoughts

of suicide. At that point, Dr. Wang left the clinic, but Eric transferred to another therapist with the goal of further improving his social skills and negative cognitions.

This case illustrates the complicated histories and symptoms that clients can bring to therapy (Liu, 2007). Luckily, Eric found a therapist who was culturally competent and who employed some of the evidence-based methods described later in this chapter and in Chapter 9.

Over the past few decades, no other area of clinical psychology has seen more intense research and debate than efforts to establish which psychological treatments work best for which clients and which problems. The idea is that clinicians should prioritize the use of therapies and assessment techniques that high-quality research has shown to be effective. As described in Chapter 1, when (a) the best-supported of these techniques are integrated with (b) experience-based clinical expertise and (c) information about clients' characteristics, culture, and preferences, the result is called *evidence-based practice* (APA Presidential Task Force, 2006; Thyer & Pignotti, 2011). What kinds of evidence are sufficient to show that a particular assessment or treatment method is empirically supported? Let's explore some of the answers to this complicated question.

Methods for Studying Psychological Treatments

Section Preview We begin by reviewing the history of psychologists' efforts to establish which treatments work best for which problems. Included in the discussion is a summary of the research designs they have used (within-subjects, between-subjects, and randomized controlled trials).

The modern era of therapy-outcome research began in 1952 when Hans Eysenck, a German-British psychologist, reviewed several experiments and concluded that the recovery rate seen in patients who receive therapy is actually lower than for those who do not. Eysenck argued that the rate of *spontaneous remission* (improvement without any special treatment) was 72% over 2 years compared with improvement rates of 44% for psychoanalysis and 64% for eclectic therapy, that is, therapy that incorporates techniques from a variety of treatment approaches (Eysenck, 1952). Eysenck's findings came as a shock to psychotherapists, and raised fundamental questions about the effectiveness of the treatments available at the time. Chief among these questions was whether the psychotherapy enterprise was worth the time, effort, and money involved, not to mention the rigorous training that therapists undergo to qualify to offer treatment. Later, Eysenck (1966) evaluated more outcome studies and, while persisting in his pessimism about the effectiveness of traditional therapy, claimed that the then-new approach known as behavior therapy produced results that were superior to spontaneous remission rates.

In retrospect, it is clear that Eysenck's comparisons and conclusions were severely flawed. His definitions of patient outcomes were vague, and his estimates of spontaneous remission were based on highly problematic indicators, including rates of patient hospital discharge and disability insurance claims filed by patients (Hunt, 1997; Rachman, 1973). Even the concept of spontaneous remission is questionable (Cartwright, 1955). For example, there may not be much that is "spontaneous" about the remission. The longer that people deal with their problems, the more opportunity there is for external factors such as social support or the occurrence of positive life experiences to contribute to improvement (Jacobson & Christensen, 1996). Nevertheless, Eysenck deserves credit for raising an extremely important question: *Is psychotherapy effective*?

Researchers tried for many years to answer this question, but they eventually came to realize that it was too broad. Part of the problem is that, as described in Chapters 8, 9, and 10, "psychotherapy" can take so many forms, it is difficult to say exactly what "it" is. About seven decades ago, an eminent psychotherapy scholar highlighted this problem when he jokingly wrote that "Psychotherapy is an undefined technique applied to unspecified problems with unpredictable outcome. For this technique, we recommend rigorous training" (Raimy, 1950, p. 93).

Starting in the 1970s, therapy-outcome research began to be influenced by Gordon Paul's (1969) more specific form of Eysenck's question, one that is sometimes referred to as the "ultimate question" about psychotherapy research: "What treatment, by whom, is most effective for this individual with that specific problem, under which set of circumstances, and how does it come about?" (p. 44). Alan Kazdin (1982) has since translated Paul's "ultimate question" into a list of outcome research goals, including to:

- Determine the **efficacy** of a specific treatment, that is the extent to which treatment works in large-scale studies run under controlled conditions.
- Compare the relative **effectiveness** of different treatments, that is, determine the extent to which a treatment is useful in the real world of clinical service delivery.
- Determine the specific components of treatment that are responsible for particular changes.

Efficacy
Describes a treatment that is shown to work in controlled studies.

Effectiveness
Describes a treatment that is useful in clinical practice.

More recently, researchers investigating psychological treatments have also sought to:

- Assess the durability of the benefits of particular treatments.

- Identify any negative side effects associated with particular treatments.
- Determine how acceptable and effective a treatment is for various kinds of clients (e.g., does a treatment work better for some ethnic groups than for others).
- Identify the cost-effectiveness of various treatments.
- Discover whether a treatment's effects are clinically significant and socially meaningful.
- Verify that treatments that work in one setting (such as the research laboratory) are also effective in other settings (such as a community mental health center).
- Establish which delivery method, such as face-to-face versus online, is associated with the best clinical outcomes.
- Evaluate how treatments lead to changes in behavior (Kazdin & Blase, 2011; Kendall & Comer, 2011).

The results of these researchers' work have led to significant advances in identifying and developing treatments that diminish the severity and intensity of the most common mental health problems. A look at the history and process of research on clinical interventions will help to highlight how far we have come as a field.

Basic Designs of Psychotherapy-Outcome Research: Past and Present

For the past several decades, researchers have tried to design and conduct their treatment outcome evaluations in such a way that the meaning of the results can be clearly understood. These efforts have required researchers to consider not only the effects of treatment, but whether those effects are large enough to be clinically, as well as statistically, significant. For example, treated clients' scores on an anxiety measure might decrease enough to suggest that the change is **statistically significant**. This would mean that, if treatment really had no effect—thus confirming what researchers call the "null hypothesis"—then seeing such a large reduction in anxiety would be rare, even if the study were to be repeated many times. However, this statistically significant improvement would not be **clinically significant** unless the clients now feel and act more like people without an anxiety disorder (De Smet et al., 2019; see Figure 7.1).

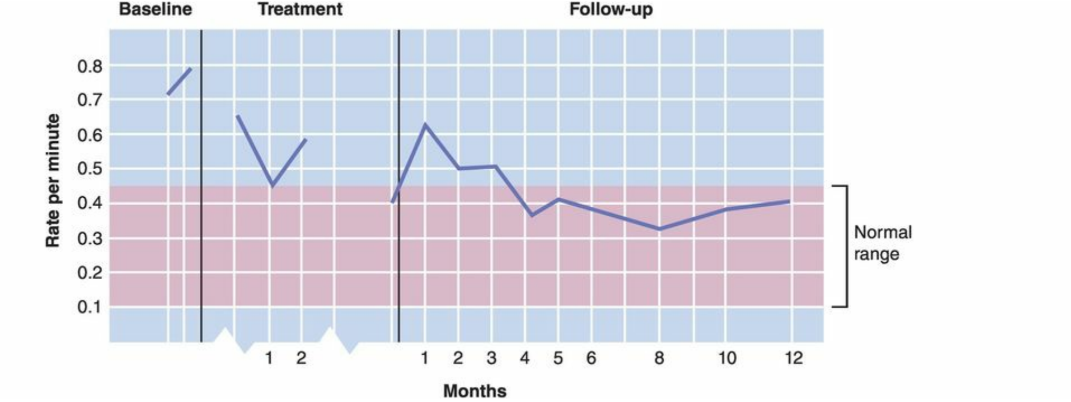

Figure 7.1 Clinical vs. Statistical Significance
The shaded area of this graph shows the range of problematic behaviors per minute displayed at home by typically developing boys. The solid line

shows the average rate of problematic behaviors for boys in a treatment program for conduct disorders. The improvement following treatment was not only statistically significant (compared with their pretreatment baseline), but also clinically significant because the boys' behavior came to resemble that of boys without a conduct disorder.

(Source: Patterson, G. R. (1974). Intervention for boys with conduct problems: Multiple settings, treatments, and criteria. *Journal of Consulting and Clinical Psychology*, *42*, 476. American Psychological Association.)

Statistically significant
Describes a difference that would rarely be seen, even after many replications of a study, if there really was no difference.

Clinically significant
Describes improvement that is large enough that clients feel and act more like people without a disorder.

Of all the research designs that can evaluate the presence of a cause–effect relationship between therapy and improvement, the most powerful is the experiment (Greenhoot, 2005). An **experiment** is an attempt

to discover the causes of specific events by making systematic changes in certain factors and then observing changes that occur in other factors. The factors that researchers manipulate are called **independent variables**; the factors in which changes are to be observed are called **dependent variables** (they are called “dependent” because they depend on the manipulations that researchers perform). In outcome research, the independent variable is usually the type of therapy that is given (e.g., cognitive behavioral treatment versus nondirective therapy), and the dependent variable is the amount of change seen in client symptoms (e.g., as measured by tests of depression or anxiety).

Experiment
A method for discovering the causes of specific events by manipulating one or more independent variables, then looking for changes in one or more dependent variables.

Independent variable
A factor that researchers manipulate in an experiment.

Dependent variable

In an experiment, a factor in which changes are to be observed.

Most psychotherapy-outcome experiments employ either within-subjects or between-subjects research designs, both of which allow the researcher to examine the effects of varying treatment conditions (the independent variable) on clients' thinking and behavior (the dependent variables). In **within-subjects designs**, clients receive a single kind of treatment, but the experimenter alters it in some way at various points and observes any changes in symptoms that might occur. In **between-subjects designs**, different groups of clients are exposed to differing treatments, and the amount and type of changes observed in each group are compared. Either within- or between-subjects designs are used in *randomized controlled trials* to provide a more statistically rigorous research methodology. We discuss each of these methods in more detail in the next sections.

Within-subjects design

Research in which changes are observed and analyzed as clients receive one or more forms of treatment.

Between-subjects designs

Research in which different groups of clients are compared after receiving differing treatments or control conditions.

Within-Subjects Research Designs. Some of the earliest research on clinical interventions was conducted using within-subjects experimental designs (Fishman, Rego, & Muller, 2011; Kazdin, 2019). The within-subjects design requires that the dependent variables (client symptoms) be measured on several occasions. As shown in Figure 7.1, the first of these observations usually takes place during a pretreatment, or baseline, period that provides a measure of the nature and intensity of a client's problematic behavior. Once baseline measures have established a stable picture, the intervention phase of the experiment begins. Here, the researcher manipulates the independent variable by introducing some form of treatment and carefully monitors the dependent variable for any changes from its baseline level.

There are several types of within-subjects experimental designs, but they all allow clinical researchers to conduct fine-grained analyses of the inner workings of therapy in real-world settings (Miltenberger, 2011). One variant is the *case study* model, in which therapists evaluate their services in clinical settings by developing a specific treatment formulation for each client, then assessing the effects of the therapy for that client using techniques similar to those of single-subject research designs (Kazdin, 2011). Single-case experiments are a flexible and efficient type of research design that can be easily adopted in clinical practice settings to make causal inferences about the impact of treatment on individual clients (Barlow, Nock, & Hersen, 2009; see Figure 7.2).

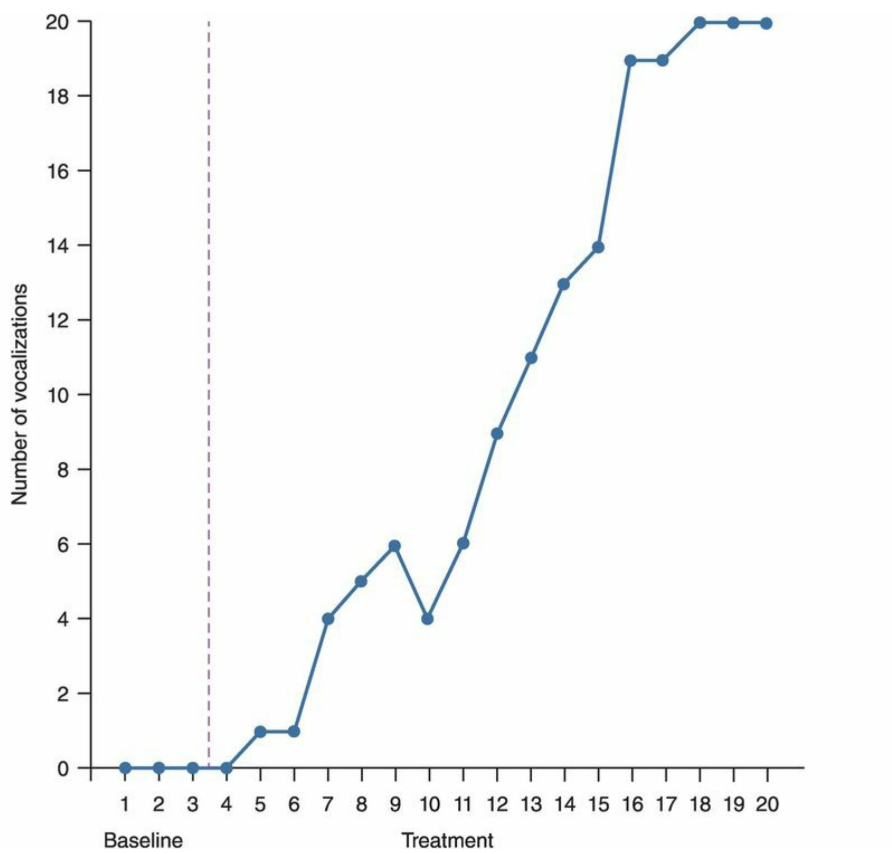

Figure 7.2 Results of a Within-Subjects Case Study in a Clinical Setting The client in this case was a 6-year-old girl, diagnosed with selective mutism because she would not talk to anyone other than the members of her family. After 3 days of baseline assessment, treatment was begun by rewarding her with her favorite sugar-free candy whenever she spoke to someone other than her family.

Within-subjects treatment research is usually conducted over time with a single client or, sometimes, a small number of clients. Indeed, single-subject, or “*N* = 1” research is a popular evaluation strategy when a new treatment is being explored or when a rare disorder is being addressed, and it allows intensive study of the treatment process (Fishman, Rego, & Muller, 2011). Despite their strengths, within-subject designs have limited generalizability. That is, they can help to establish whether a given treatment works for one or

a few clients, but they usually cannot tell us how well they would work for other clients with similar problems. As a consequence, between-subjects designs are more commonly used in therapy-outcome research.

Between-Subjects Research Designs. The simplest example of a between-subjects experiment on therapy outcome is one in which the researcher manipulates an independent variable by giving treatment to one group of clients—the *experimental* group—and compares any observed changes with those seen in a *control* group of clients who received no treatment. The intensity of the clients' problematic symptoms (the dependent variable) are measured in both groups before the study (the *pre-test*), shortly after the treatment period ends (the *posttest*), and perhaps also at various posttreatment intervals (the *follow-up*).

It is essential that clients be *randomly assigned* to experimental or control groups because, given a large enough number of clients, this procedure makes it likely that the treatment and control groups will be approximately equivalent in age, severity of disorder, gender, race/ethnicity, socioeconomic status, and other important variables that might influence treatment outcome. If clients are not randomly assigned to conditions, any between-group differences in symptoms at the end of the experiment might be attributable to differences that existed between groups before the study began.

Statistical comparisons between outcomes for treatment and no-treatment groups are just a first step in therapy-outcome research. After all, even large and statistically significant differences between a treatment and a no-treatment group tell us only that administering that treatment appears to be better than doing nothing. The simple treatment/no-treatment design cannot shed light on the more complex questions that therapy-outcome researchers

want to address. More stringent designs have compared one treatment with *attention-control* conditions in which clients meet with a therapist for the same number of sessions, and for the same amount of time, as those in the treatment group, but receive no specific treatment. Including this condition in the experimental design allows researchers to measure the **nonspecific effects** (sometimes called placebo effects) of meeting with a psychologist, including receiving the kind of attention and social support that can raise a client's expectancies for improvement. When the amount of improvement seen in the attention-control (sometimes called placebo control) group is statistically subtracted from that seen in the specific treatment group, we can attribute the remaining effect to the specific treatment being evaluated. Researchers want to know whether a treatment does, indeed, offer benefits beyond those of nonspecific therapy elements like those that can be offered by a close friend or religious advisor. Attention controls have become increasingly common in intervention research.

Nonspecific effects
Elements of a therapy program other than the specific procedures used in a treatment.

In another widely used between-subjects design, clients are randomly assigned to one of two treatments whose outcomes are then compared. This design was used in one study to compare the effects of motivational interviewing plus cognitive behavior therapy with interviewing alone in

reducing alcohol abuse (Morgenstern et al., 2007). Studies like this may also include conditions which offer the nonspecific features of attention-control groups along with a minimal amount of treatment, usually a treatment that would not be expected to have any positive impact on anxiety, depression, or other problems being addressed in the experiment. Sometimes known rather sarcastically as "intent to fail" groups (Westen & Bradley, 2005), they provide a control for both the nonspecific effects found in any therapeutic relationship and the impact of participating in a real, though not ideal treatment. Of course, such designs essentially stack the deck in favor of the treatment being evaluated. This is why many researchers choose to compare one treatment of interest, usually a new one, with one or more treatments that are considered "*bona fide*." *Bona fide* interventions are intended to be therapeutic for the problems being addressed, are based on a coherent theoretical rationale, have been widely used for a long time, and are supported by a strong research foundation. This kind of head-to-head comparison is one of the most rigorous designs in therapy-outcome research, but it does have some limitations. For instance, if both therapies show similar effects, in the absence of, say, a placebo control condition, it is difficult to know whether both worked equally well or both worked equally badly. Also, looking only at average results in large groups, we may not see that Treatment A is more effective for one subgroup (e.g., older adults) while Treatment B is more effective for another subgroup (e.g., middle-aged adults).

Looking beyond the question of which of two therapies is superior for a particular problem, researchers also want to know which *aspects* of a therapy are most associated with positive outcomes. In a research design called *dismantling*, researchers can "take apart" treatments that are known to work

in order to identify their most therapeutically effective components (Dobson & Hamilton, 2009). For example, if a treatment involves relaxation training, education, and homework, a dismantling study would randomly assign some clients to receive only the relaxation component, whereas others would receive relaxation and education, and still others would receive all three. Once they better understand which aspects of the treatment are most crucial for clients' improvement, clinical scientists can streamline the treatment by using only its most beneficial elements (Dobson & Hamilton, 2009). The opposite of the dismantling design can be seen in *additive* designs, in which researchers start with one treatment component, then evaluate the effects of adding additional ones, one by one, so that the incremental benefits of each new component can be measured.

Between-subjects research designs are widely used by therapy researchers because they allow manipulation of several independent variables simultaneously rather than sequentially, as required by within-subjects designs. Compared to within-subject designs, their results also tend to have greater **external validity**, which means that they usually generalize more broadly to other clients and treatment situations. Between-subjects designs tend to be expensive, however. It usually takes many clients and a large research staff to recruit, organize, and treat groups of the size necessary for powerful statistical analyses of results (Greenhoot, 2005).

External validity

The degree to which the results of a particular study are likely to apply to other clients and treatment situations.

Randomized Controlled Trials. Most federally funded research on treatment outcome currently focuses on *randomized controlled trials* (RCTs), which utilize either within- or between-subjects designs (Comer & Kendall, 2013). Although not without their critics (Carey & Stiles, 2016), RCTs are generally considered the "gold standard" by which treatments are evaluated and consequently adopted into clinical practice. This judgment is based largely on the fact that the design of RCTs have high **internal validity**; that is, they do a good job of controlling for factors that could mislead researchers into believing that an ineffective treatment is effective (Lilienfeld, McKay, & Hollon, 2018).

Internal validity
The degree to which the design of an experiment includes enough control over potentially misleading influences that researchers can draw accurate conclusions about the causes of their results.

Specifically, RCTs are set up so that the clients in each experimental and control condition have about the same demographic characteristics and a clinical problem that is of the same type and severity. This is done partly by selecting clients who are typical of people with their clinical problem, but also by randomly assigning them to the trial's various conditions to ensure that any remaining individual differences—such as in sensitivity to nonspecific treatment effects or tendency to improve (or worsen) over time

—are distributed about evenly across groups. There is strict control, too, over the treatments to be administered. The procedures are carefully specified and then monitored over the course of the trial to ensure that clients in each treatment or control group are receiving the same experience, and the experience they are supposed to have, regardless of which particular therapist they happen to see. There are other controls as well, including checks to ensure that clients are not at the same time receiving treatment from other sources. With all these factors under experimental control, researchers can more confidently conclude that the benefits appearing during and after treatment were actually caused by that treatment.

RCTs not only allow better control over threats to internal validity, but because clients are selected to be representative of their diagnostic and demographic groups, the results also tend to have higher external validity. This means that knowledge gained from RCTs is more likely to be replicable by others. Thus, all things being equal, clinical scientists should assign greater weight to well-conducted RCTs than to other designs in the selection of psychological treatments.

The results of RCTs are normally presented in accordance with the *Consolidated Standards of Reporting Trials* (CONSORT Standards), which were updated in 2010 (Schultz, Altman, & Moher, 2010). Researchers who follow these standards present flow charts portraying the progress of clients through each stage of the study, including screening, recruitment, random assignment, treatment, and follow-up. Figure 7.3 shows an example of a randomized controlled trial in which first-year college students who reported at least two episodes of heavy drinking within the past month were randomly assigned to receive either motivational interviewing along with a substance-free activity session (SFAS) or a control condition of motivational

interviewing plus relaxation training (Murphy et al., 2012). This CONSORT flowchart shows how many participants were screened out of the study, how many completed the treatment, and how many ultimately completed the 1-month and semester-long follow-up assessments. The results of this RCT showed that motivational interviewing plus SFAS (which included an individual therapy session to discuss how to reduce the negative impact of substance abuse on students' academic and career goals) was superior to motivational interviewing plus relaxation training in reducing alcohol problems at both follow-up assessments (Murphy et al., 2012). This study illustrates the importance of following specific steps involved in conducting RCTs and in reporting results in a way that is consistent with the CONSORT guidelines.

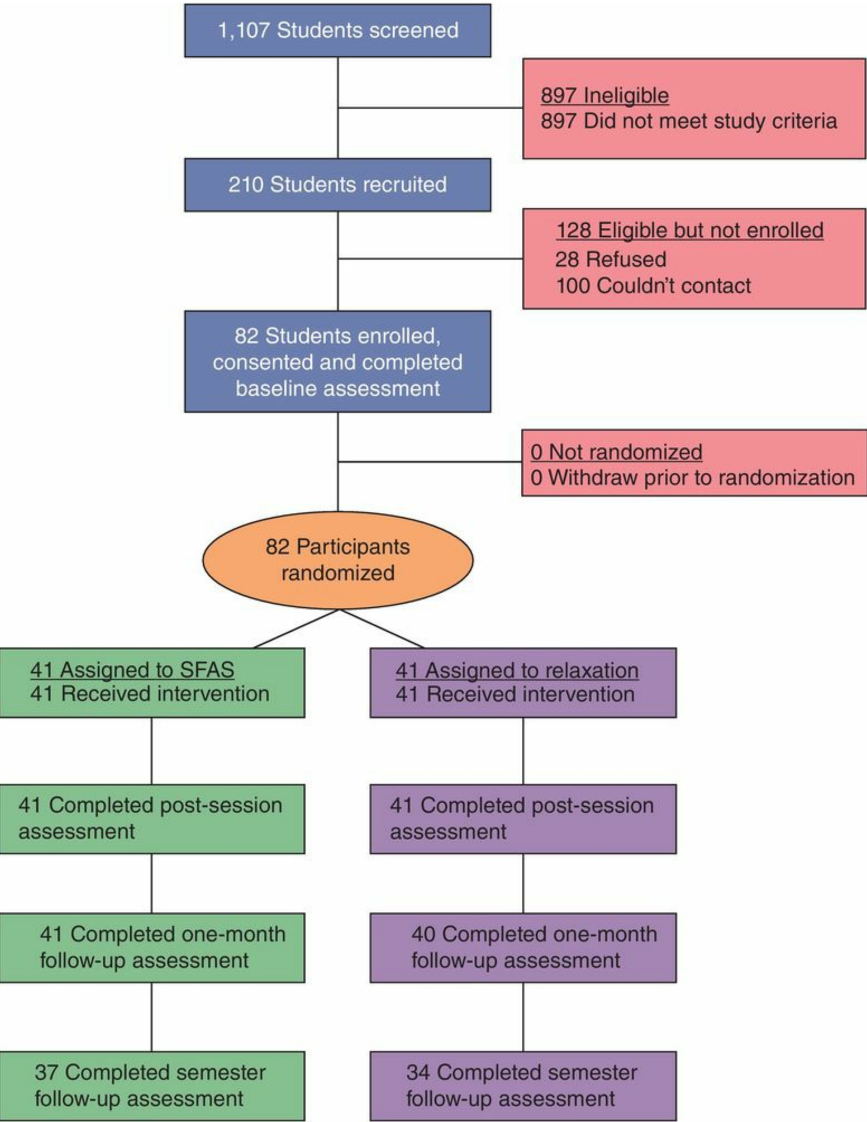

Figure 7.3 An RCT Flowchart

This diagram illustrates the recruitment, intervention, group assignment, and follow-up assessment of an RCT of the motivational interviewing described in Chapter 8.

(Source: Murphy, J. G., Dennhardt, A. A., Skidmore, J. R., Borsari, B., Barnett, N. P., et al. (2012). A randomized controlled trial of a behavioral economic supplement to brief motivational interventions for college drinking. *Journal of Consulting and Clinical Psychology*, *80*, 876–886.)

Some variants on RCT designs allow for greater flexibility and more efficient testing of multiple research questions within the same study. In one of these, called the *leapfrog design*, sophisticated statistical analyses allow researchers to discontinue poorly performing treatments and/or begin using potentially better ones during the course of the trial (Blackwell et al., 2019). There are also *Sequential, Multiple Assignment, Randomized Trial (SMART)* designs that allow multiple points of randomization within a trial so that later stages of treatment can be adjusted depending on how the first part of treatment went (Lei et al., 2012). Suppose, for example, that Rachel Jackson's father, James, had taken part in a SMART design study of the effects of motivational interviewing on problem drinking in which half the participants completed motivational interviewing and half were in a psychoeducation control condition. The progress of all participants would be tracked throughout the trial, but the SMART design could be set up so that, halfway through therapy, a randomly selected half of those who were not responding well would be given additional treatment, such as some couples therapy sessions. At the end of a SMART trial like this, the researchers could not only compare the effects of motivational interviewing versus psychoeducation, but also determine whether initial non-responders would become responders if exposed to supplemental couples therapy.

In Review Methods for Studying Psychological Treatments

Types of Experiments Used in Psychotherapy Research	**Characteristics**	**Advantages and Disadvantages**
Within-subjects designs Case studies N = 1 studies	Clients' symptoms are measured during pretreatment, treatment, and posttreatment phases. Treatment may be altered, stopped, and restarted at various points.	+ Allow intensive study of treatments or disorders. − Have limited external validity (generalizability).
Between-subjects designs Treatment vs. no treatment vs. various control conditions Comparisons of different treatments Identifying "active ingredients" (dismantling studies)	Clients are randomly assigned to various experimental or control conditions. Symptoms are measured before and after the experiment.	+High internal validity, allowing identification of cause–effect relationships between treatments and outcomes. +More generalizable than within-subjects designs. −Expensive and complicated to conduct.

Elaborating treatment elements (additive designs)		
Randomized controlled trials Within- or between-subjects designs	Use homogeneous and representative client samples, random assignment to conditions, highly structured treatments, and validated measurements.	**+**High internal validity created in the laboratory allows identification of cause–effect relationships. +Selection of representative clients allows higher generalizability (external validity). −Unrealistically rigid controls may reduce replicability of results in normal clinical situations.

Test Yourself

1. The factors that researchers manipulate in a treatment outcome experiment are called ___________; the factors in which changes are to be observed are called ____________.

2. When appropriately conducted, randomized controlled trials have high _____________ validity.

3. Clinical scientists assign greater weight to the results of well-conducted _________________ than to other research designs when selecting psychological treatments.

You can find the answers in the Answer Key at the end of the book.

Results of Research on Individual Treatments

Section Preview Here we review the results of research on the effects of individual treatments based on box score reviews, meta-analytic studies, client satisfaction surveys, and outcome studies, and describe recommendations about how best to translate research knowledge into evidence-based practices that are most likely to maximize the benefits of psychological treatments. We also consider research on the impact of common or nonspecific factors in treatment (therapist variables, client variables, and relationship variables).

The results of thousands of therapy-outcome studies have been summarized and codified in various ways over the last three decades—initially by using box score reviews and more recently by using meta-analytic reviews, both of which we describe in the next section. Researchers have also used client satisfaction surveys to explore the impact of psychological treatments. These efforts have led to the identification of empirically supported treatments, and that knowledge has guided evidence-based practices that are most likely to maximize the benefits of psychological treatments.

Client Satisfaction Surveys

In the 1990s, while researchers were trying to ascertain whether therapy was useful, a huge public survey was undertaken by *Consumer Reports* magazine (Seligman, 1995). Approximately 4100 respondents who had seen a mental health professional in the previous 3 years were asked to rate the degree to which formal treatment had helped with the problem that led them to therapy, how satisfied they were with the treatment they received, and how they judged their “overall emotional state” after treatment.

Their responses indicated that: (a) about 90% of clients felt better after treatment, (b) there was no difference in the improvement of clients who had psychotherapy alone or psychotherapy plus medication, (c) none of the approaches to psychotherapy outlined in Chapter 2 was rated more highly than the others, and (d) greater improvements were associated with treatment by psychologists, psychiatrists, and social workers compared with family physicians or marriage counselors. Later, even larger, studies of psychological treatment found about the same high ratings of client satisfaction (e.g., Lippens & Mackenzie, 2011).

Client satisfaction surveys are not nearly as scientific as randomized controlled trials because, for one thing, they are not based on objective outcome measurements. Instead, they are based on people’s memories, subjective feelings, motivation to believe in the value of their therapy, and other factors that might lead them to say that treatment helped even if it didn’t—or didn’t help much. In addition, those who choose to respond to a survey request may not accurately represent the entire client population. For example, most respondents might have been people who were either very

satisfied or extremely unhappy with their treatment. Still, these surveys provide clinical researchers with provisional evidence about clients' overall view of therapy experiences.

Box Score Reviews

A more scientific approach to summarizing outcome research is the narrative, or box score, review (e.g., Lambert & Bergin, 1994; Lambert, Shapiro, & Bergin, 1986; Weisz, Donenberg, Han, & Weiss, 1995). In a **box score review**, researchers make categorical judgments about whether each outcome study yielded positive or negative results and then tally the number of positive and negative outcomes. Reviewers who use this method have been criticized (including by one another) for being subjective and unsystematic in the way they integrate research studies. Another problem with narrative reviews is that the sheer number of outcome studies makes it difficult for reviewers to weigh properly the merits and results of each study. That is, it is highly unlikely that all treatment outcome studies are created equal. Disagreements over these results made it clear that an alternative to box score analysis was needed, one that would allow researchers to quantify and statistically summarize the effects of each outcome study, separately and in the aggregate.

Box score review

A summary of outcome research which counts the number of studies that are judged to give positive and negative results.

Meta-Analytic Studies

One such alternative is **meta-analysis**, a quantitative technique that standardizes the outcomes of a large number of studies so they can be compared or combined (Ellis, 2010). In essence, meta-analysis combines the results of many studies and treats them as though they were one large study. To do so, it uses a statistic called **effect size** to quantify the differences in outcome for all clients who receive treatment and all those who do not. This statistic is calculated in the following way: the mean score on some dependent measure (such as anxiety) in the control group is subtracted from the mean on that same measure in the treatment group. The result is then divided by the standard deviation of the control group. In other words, an effect size indicates the average difference in outcome between treated and untreated groups across all the studies included in the meta-analysis. It gives us a sense of the magnitude of the overall effect of a treatment. Effect sizes can also be calculated to compare two different treatment groups rather than just treatment and no-treatment groups.

Meta-analysis
A statistical technique for standardizing and summarizing the outcomes of many therapy studies.

Effect size

The average difference in outcome between treated and untreated groups across the studies in a meta-analysis.

Looking at effect sizes measured immediately after therapy ends, or in some cases, months after treatment, indicates how much better off the average treated client was compared with the average untreated client. Effect sizes from 0.20 to 0.50 are usually considered "small," those between 0.50 and 0.80, "medium," and those above 0.80, "large."

Mary Smith and Gene Glass were the first to apply meta-analysis to the results of therapy-outcome research. Their classic 1977 paper concluded that, on average, psychotherapy was fairly effective, with a medium effect size of 0.68 relative to no treatment (Smith & Glass, 1977). The results of their second, much larger meta-analysis of 475 outcome studies found that the average treated client was better off than 80% of untreated individuals; there was a large effect size of 0.85 (Smith, Glass, & Miller, 1980). Over the years, other research teams have performed other meta-analyses using different statistical methods or differently selected sets of studies (e.g., Lambert & Bergin, 1994; Munder et al., 2019; Shapiro & Shapiro, 1982; Stewart & Chambless, 2009; Tolin, 2010; Weisz, Jensen-Doss, & Hawley, 2006). In general, these analyses have confirmed the conclusion that psychological treatment is an effective intervention for a wide variety of psychological disorders, and that its overall effectiveness is medium to large in magnitude.

Thinking Scientifically Are All Forms of Psychotherapy Equally Effective?

This conclusion supports what psychotherapists already assume, but most of them also assume that the methods of *their* approach to treatment work better than those of other therapists (Mandelid, 2003).

What am I being asked to believe or accept?

They cannot all be right, and some researchers claim that all of them are wrong. These researchers argue that the success of psychotherapy doesn't have much to do with theories about the causes of behavior disorder or even with the specific treatment methods used in treatment. All approaches, they say, are equally effective, probably because of beneficial, but nonspecific, factors we described earlier. This claim has been called the "Dodo Bird Verdict," after the *Alice's Adventures in Wonderland* character who, when called on to judge who had won a race said that, "Everybody has won, and all must have prizes" (Duncan, 2002; Luborsky, Singer, & Luborsky, 1975).

What kind of evidence is available to support the claim?

Those who make this claim point to the results of the meta-analyses we just described, which show that the three main treatment approaches—psychodynamic, behavioral/cognitive behavioral, and humanistic— are associated with about the same degree of success (e.g., Keefe et al., 2014; Kivlighan et al., 2015; Luborsky, Rosenthal, & Diguer, 2002; Roberts et al., 2017; Shadish et al., 2000; Steinert et al., 2017; Weisz, McCarty, & Valeri, 2006).

Are there alternative ways to interpret the evidence, including those that my biases and preconceptions might have kept me from seeing?

Those who question the Dodo bird verdict point out that there are limits to the conclusions that can be drawn from the results of meta-analyses of psychotherapy effects. For one thing, those results depend in part on what treatment targets, outcome measures, and treatment categories are chosen. If, for example, one meta-analysis of a depression treatment looks at only one well-specified outcome measure—say, clients' scores on a single test of depression—whereas a second meta-analysis of that same treatment includes scores on several tests, some of which also measure anxiety, the results of those two meta-analyses would not likely be the same.

Results might differ, too, depending on whether a meta-analysis focused on treatment for one type of disorder or many. Suppose that Therapy A works better than Therapy B in treating anxiety, but that Therapy B works better than Therapy A in treating depression. If your meta-analysis compared the effectiveness of these two treatments only with anxiety clients or only with depression clients, there would be a difference in favor of one therapy or the other. However, if your meta-analysis combined the results of these treatments with both kinds of clients, the average effects of each therapy would be about the same, making it appear that, as the Dodo bird verdict suggests, they are about equally effective. You would also see little difference between treatments if you chose to compare those that are quite similar. Suppose, for example, that a meta-analysis of only bona fide treatments included some, like cognitive therapy and cognitive

behavior therapy, that involve similar procedures. The results might appear to support the Dodo bird verdict, but could actually be misleading because the fact that two treatment approaches performed about the same does not mean that *all* treatments are about equally effective.

Inconsistencies in the quality of the studies included in your meta-analysis can also mask differences in treatment effects. As already mentioned, the highest quality studies randomly assign clients to conditions, clearly define target symptoms, and use reliable and valid outcome measures. They also reduce experimenter bias by ensuring that those who rate clients' improvement are unaware of ("blind" to) which treatment or control condition the clients were in. Now imagine that Therapy X is actually better overall than Therapy Y, but several of the studies of Therapy X you included in your analysis were of much lower quality than those of Therapy Y. That difference might drag down the apparent effectiveness of Therapy X, making it appear only about as good as Therapy Y. In other words, depending on how meta-analyses are constructed and conducted, they may or may not be able to reveal important differences in the effectiveness of particular treatments for specific problems (Ehlers et al., 2010).

What additional evidence would help to evaluate the alternatives?

Debate is likely to continue over whether, on average, all forms of psychotherapy are about equally effective, but to many researchers, this is the wrong question. They argue that it's pointless to compare the effects of psychodynamic, humanistic, and behavioral methods in

general. It is more important, they say, to address the "ultimate question" about psychotherapy we mentioned earlier: "What treatment, by whom, is most effective for this individual with that specific problem, under which set of circumstances, and how does it come about?" (Paul, 1969).

What conclusions are most reasonable given the kind of evidence available?

Research on this question is bearing fruit, and as we describe in the next section, shows that some psychotherapies are indeed more effective than others, not necessarily overall, but for particular problems. One meta-analysis found, for example, that cognitive behavior therapy was more beneficial in cases of social anxiety disorder than psychodynamic psychotherapy, interpersonal psychotherapy, mindfulness, and supportive therapy (Mayo-Wilson et al., 2014). Another meta-analysis found an effect size that favored cognitive behavior therapy over other psychotherapies in the treatment of anxiety disorders in general (Tolin, 2014). So meta-analysis can improve estimates of the effectiveness of various treatments, but the precision of those estimates depends on the quality of the studies examined and the approach taken to extracting data from those studies.

Empirically Supported and Evidence-Based Treatments

As we just noted, client surveys, box score reviews, and meta-analyses suggest there are often relatively few significant differences in the *overall* outcomes of various types of bona fide treatment, but that doesn't mean that all treatments have the same effects for all clients with all problems. Accordingly, in 1993, APA Division 12 (now known as the Society of Clinical Psychology, or SCP) convened a special task force to look more closely at the results of psychotherapy-outcome research to determine which specific treatment interventions were most strongly supported by empirical research as being effective for particular kinds of problems. This *Task Force on Promotion and Dissemination of Psychological Procedures* began by establishing a set of criteria for research designs capable of reaching scientifically-grounded conclusions about the effectiveness of clinical interventions. They then reviewed the massive therapy-outcome literature to determine what all those studies said about the effects of various treatments. In 1995, the Task Force published a preliminary list of 25 treatments that high-quality empirical research had identified as *efficacious* (Seligman, 1995). The list was updated in 1996 and again in 1998. The 1998 list included 71 treatments (Chambless et al., 1998). The task force's original 1995 report used the term *empirically validated* to describe those interventions that met its criteria for efficaciousness. However, many clinicians and researchers believed that this term was too strong and that it implied that certain interventions had been "proven" to work. Hence, they argued that there was not a single, final "answer" as to which treatments

“worked.” Accordingly, the next report of the Task Force referred to *empirically supported* treatments (ESTs).

By 2001, the Task Force, along with seven other work groups using similar methods, had classified 108 treatments for adults and 37 for children as being either:

- *Well-established/efficacious and specific* (that is, supported by at least two rigorous randomized controlled trials in which treatment showed superiority to placebo–control conditions or another bona fide treatment, or by a large series of rigorous single-case experiments),
- *Probably/possibly efficacious* (that is, supported by at least one rigorous randomized controlled trial in which treatment showed superiority to placebo–control conditions or another bona fide treatment, or by a small series of rigorous single-case experiments), or
- *Promising* (that is, supported by studies whose research designs produced less convincing evidence than those in the first two categories) (Chambless & Ollendick, 2001).

Dianne Chambless, Professor of Psychology at the University of Pennsylvania played a central role in early efforts to determine criteria for identifying empirically supported treatments.

(Source: Supplied with permission of Prof. Dianne Chambless.)

Although there is a growing consensus regarding the importance of identifying ESTs, the approach and criteria it used have remained controversial. For example, the criteria for a *well-established/efficacious and specific* treatment are based on the results of at least two randomized controlled trials. This criterion seems to set a rather low bar for determining that a treatment is efficacious (Tolin et al., 2015). Further, this approach counts only "hits" (the number of studies that found positive results); it ignores the "misses." So if two randomized controlled trials find Therapy X

to be efficacious, four studies find it to be no better than an attention-placebo condition, and eight studies find that it is not as good as a placebo condition, the criteria for designating Therapy X as a “well-established” EST would still be satisfied. By not taking into account such mixed positive and negative findings, the EST approach can easily misrepresent the available evidence (Herbert, 2003).

Another concern about the EST approach is its heavy emphasis on data from controlled experiments and randomized controlled trials, which means there is a built-in bias against treatments that might not lend themselves to that kind of evaluation. For example, there is a long history of evaluating cognitive behavioral treatments with RCTs, partly because these treatments are often relatively brief and focus on specific, objective measures of behavior change. It is not surprising, then, that between 60 and 90% of the treatments on the current list of ESTs are cognitive behavioral in nature (Chambless & Ollendick, 2001). This fact has led some whose allegiance is to other treatment modalities to argue that the list of ESTs is biased against treatments that might be supported by less objective sources of evidence, including clinical judgments, case reports, discussions with colleagues, and personal experiences (Laska, Gurman, & Wampold, 2014). Advocates of the EST list agree, but point out that these other sources of evidence are generally less able to support cause–effect inferences when compared to evidence derived from RCTs and controlled experimental designs.

Does this mean that less objective evidence has no value? Certainly not. As we have said before, the evidence-based practice of clinical psychology seeks to integrate information from RCTs and controlled experiments with experience-based clinical expertise and patient values and preferences. Part of the value of that clinical expertise is in filling some of the gaps in knowledge

about treatment that controlled research leaves open. These gaps appear partly because RCTs deliver treatments to groups of clients who are specially selected for having the same problem. And as described later, they also require therapists to conduct those treatments in strict accordance with standardized *treatment manuals* (or at least a well-described treatment protocol) rather than on the basis of their own preferences and experiences (Baardseth et al., 2013; Beutler, 2002). These steps greatly increase the internal validity of RCTs, but may limit their external validity, or generalizability. Accordingly, some have suggested that in addition to evaluating the *efficacy* of treatments, which is measured in controlled situations, there should be greater emphasis on *effectiveness* research, which as mentioned earlier, focuses on the degree to which the benefits of efficacious treatments will generalize to clinically representative situations where the characteristics of clients and their problems are likely to be more diverse (Tolin et al., 2015; Westen, Novotny, & Thompson-Brenner, 2004).

Indeed, the effort to identify efficacious and effective treatments continues on many fronts. For example, the Society of Clinical Psychology continues to revise its lists of ESTs and maintains a website that lists updated "Research-Supported Psychological Treatments." An APA Presidential Task Force on Evidence-Based Practice (2006) categorized these treatments according to whether they have:

1. Strong research support (similar to the "well established" definition in the 2001 version of the list),

2. Modest research support (similar to "probably efficacious"), or

3. Controversial research support (meaning that there are conflicting results or that though the treatment is shown to be efficacious, some claims made

about the treatment are not based on empirical evidence).

Try this The results presented on the SCP website are too numerous to list here, but Table 7.1 should give you some idea of the kinds of treatments that have garnered strong research support for selected clinical problems. We encourage you to visit the website at https://www.div12.org/psychological-treatments so that you can browse the latest list yourself.

Table 7.1 Research-Supported Psychological Treatments (Selected)

Psychological Treatment	**Diagnosis or Clinical Problem**
Acceptance and Commitment Therapy	Chronic pain
Behavior Therapy/Behavioral Activation	Major depressive disorder
Behavioral Couples Therapy for Alcohol Use Disorders	Alcohol use disorder
Cognitive Behavior Therapy	Bulimia nervosa Major depressive disorder Generalized anxiety disorder
Cognitive Therapy	Panic disorder
Dialectical Behavior Therapy	Bi-polar disorder
Exposure and Response Prevention	Obsessive–compulsive disorder

Interpersonal Therapy	Bulimia nervosa
Motivational Interviewing/Motivational Enhancement Therapy (MET)	Substance use disorder
Problem-Solving Therapy	Major depressive disorder

Source: Based on data from https://www.div12.org/psychological-treatments/

Research aimed at identifying efficacious and effective treatments is now being accompanied by efforts to encourage clinicians to adopt these treatments with the clients for whom they would be most appropriate. An example of this latter effort is the National Institute of Clinical Excellence (NICE) standards in the United Kingdom (Baker & Kleijnen, 2000). The NICE guidelines were implemented to ensure that clinicians are employing empirically supported treatments for specific disorders (see https://www.nice.org.uk/guidance/conditions-and-diseases/mental-health-and-behavioural-conditions). In the United States, the Veterans Health Administration, which serves nearly six million clients, has implemented a system-wide dissemination of information about empirically based treatments for posttraumatic stress disorder, depression, and other serious mental disorders (Ruzek, Karlin, & Zeiss, 2012). The American Psychological Association has also begun to produce clinical practice guidelines (e.g., https://www.apa.org/depression-guideline).

Some clinical scientists are also seeking to identify potentially harmful therapies (PHTs), as operationally defined by the following three criteria (Lilienfeld, 2007):

1. They have demonstrated harmful psychological or physical effects in clients or others (e.g., relatives of clients).

2. The harmful effects are enduring, not merely a short-term worsening of symptoms during treatment.

3. The harmful effects have been found repeatedly by independent investigative teams.

One example of a PHT is Critical Incident Stress Debriefing, which is designed to prevent symptoms of PTSD and related anxiety disorders among individuals exposed to extreme stressors. These individuals are strongly urged to discuss their emotions within 48 hours of the traumatic event, but this method may backfire for clients who prefer to handle upsetting events on their own. Other examples include recovered memory therapies, which claim to help clients retrieve traumatic memories that had been buried in the subconscious but may instead inadvertently create false memories of abuse. Still others on the PHT list are boot camps for conduct disorder, which may produce harm in some clients. Identification of PHTs is still in its infancy, but clinical scientists hope this endeavor will prove useful in discouraging the use of these treatments by well-meaning clinicians and thus protect clients against possible harm.

The latest developments in therapy-outcome research reflect efforts not only to understand which therapies are most effective for which problems, but also to identify a broader array of therapeutic practices through which treatment is likely to produce the maximum benefit to clients. This may involve shifting research attention away from the question of which “brands” of treatment are the best, and toward identifying a set of empirically supported *principles of change* that may explain the efficacy of many

different therapies (Hofmann & Hayes, 2019; Rosen & Davison, 2003). It has been suggested, for example, that what a treatment package is called may be less important in determining its outcome than the nature of the principles on which it operates. Some of the principles that have been identified so far include cognitive restructuring, repeated exposure to anxiety-provoking stimuli, and positive reinforcement of more adaptive behaviors. It is hoped that we will eventually identify all of them, thus further advancing the ability of clinical psychologists to conduct evidence-based practice.

Evidence-Based Practice

We introduced the idea of *evidence-based practice* in Chapter 1 by summarizing the work of a 2006 APA Presidential Task Force on the subject. The task force described evidence-based practitioners as clinicians who pay attention to laboratory research evidence, but who also recognize the importance of other sources of evidence, including that coming from clinical experience, and from what they have learned about the values and preferences of their clients. We noted that, together, these sources of evidence form a "three-legged stool" that serves as the platform for evidence-based practice (see Figure 1.3).

The formation of this task force was an attempt by the APA to bring together researchers and clinicians to find the many ways that treatments can be shown to be effective in the real world. Unlike the ESTs approach, which focuses only on specific therapeutic techniques, evidence-based practice is a more general approach to clinical decision-making that has clearly caught on throughout the research and clinical realms (e.g., Brown et al., 2019). There is now a two-volume *Handbook of Evidence-Based Practice in Clinical Psychology* (Sturmey & Hersen, 2012a, 2012b) focused on childhood, adolescent, and adult disorders. There have also been special issues or special sections on evidence-based practice in many prominent peer-reviewed journals, including the *Journal of Consulting and Clinical Psychology* (LaGreca, Silverman, & Lochman, 2009), *Clinical Psychology: Science and Practice* (Youngstrom & Kendall, 2009), the *Journal of Clinical Psychology* (Morales & Norcross, 2010), the *Journal of Latina/o Psychology* (Cardemil & La Roche, 2017), and *Psychotherapy* (Norcross & Lambert, 2011). Some

of these, like the one that appeared a few years ago in *Clinical Psychology Review*, have focused specifically on how evidence-based practice can inform new approaches to diagnosis, treatment development, and training issues (Gaudiano & Miller, 2013).

The development of evidence-based practice represents the latest stage in the history of clinical psychologists' efforts to understand and improve psychotherapy. In the early stages, researchers tried to determine if psychotherapy was efficacious in controlled settings and effective in the real world of clinical practice. In the next stages, researchers sought to discover which forms of psychotherapy were superior, and in recognition of Gordon Paul's (1969) "ultimate question," about which treatments work best for which clients and which problems. Today, state-of-the-science work in evidence-based practice combines research on specific treatments (e.g., from outcome studies, randomized controlled trials, case studies, and meta-analyses) with research on the impact of client and therapist characteristics, the nature of the therapeutic relationship, and knowledge based on clinicians' professional experiences and expertise. It recognizes that clinical science and clinical practice depend on each other and that neither can work as productively in isolation as they can in concert. Indeed, the hope is to see the dawning of a new era of evidence-based practice in which research evidence and clinical skill can be happily married.

All couples have their differences, though, and the marriage known as evidence-based practice is no exception. As we mentioned in Chapter 1, there is some disagreement about which of the three legs of the evidence stool should carry the most weight in clinical decision-making. Although some believe that evidence from all three legs should be given equal weight, others have argued that the scientific evidence leg should be relied upon more

heavily than the other two (e.g., Canadian Psychological Association Presidential Task Force on Evidence-Based Practice of Psychological Treatments, 2014). We tend to agree with this latter view because we believe that if clinicians don't recognize the importance of scientific evidence, they may fail to adopt effective treatments while continuing to use interventions that may be ineffective or even harmful. This view is also reflected in a statement endorsed by more than 35 mental health organizations suggesting that the process of decision-making for mental and behavioral health care in evidence-based practice starts with the best available basic and applied empirical research evidence and then considers how well that evidence fits given "contextual factors such as developmental level, community/cultural needs, the settings in which the services occur, barriers to services, and the strengths and assets of individuals and communities" (Coalition for the Advancement and Application of Psychological Science, 2018). The statement also emphasizes the importance of continuously measuring the effects of clinical service to determine if it is helping individual clients.

Despite some progress in reaching agreement about what constitutes evidence-based practice, there remains a notable gap between what the best evidence from scientific research recommends and what practicing clinicians do. In fact, many clinicians not only ignore the results of research on empirically supported therapies, but resist the whole idea of evidence-based practice. There are several reasons for this resistance (Lilienfeld et al., 2013). One of them has been called *naïve realism,* the error of assuming that one can always trust one's perceptions. It can lead clinicians to conclude erroneously that the changes they see in their clients are invariably due to the specifics of the intervention they are using when in fact it may be due to a host of other specific and nonspecific factors. Resistance to evidence-based practice can

also be traced to misconceptions about human nature. For example, the false belief that effective psychotherapy always requires revisiting one's past may prevent clinicians from adopting empirically supported treatments that emphasize teaching clients the coping skills they will need in the future. A third source of resistance is an unfortunate and widespread misunderstanding of what it means to engage in evidence-based practice. Many clinicians assume, for example, that doing so would restrict their ability to be innovative and creative in their practices, that they would be forced to take a "cookie-cutter," "one-size-fits-all" approach to treatment, that evidence-based practice suppresses the influence of the therapeutic relationship and other nonspecific factors in therapy, and that evidence-based practice would require them to ignore the advice of experienced colleagues or other evidence from anywhere except randomized controlled trials.

Fortunately, all of these beliefs are false, but other concerns about evidence-based practice may indeed place limits on its applicability. In particular, many of the studies used to evaluate the efficacy of various treatments have not included enough members of racial and ethnic minority groups. As a result, we often do not know whether a given treatment will work as well across diverse client populations. This is a critical area for future research.

More generally, some unconvinced clinicians see evidence-based practice as unnecessary because they believe that all treatments are equally effective. As we mentioned earlier, that tends not to be the case for all clinical problems, but there are indeed some factors, such as a strong therapeutic alliance with the client, that likely do contribute to the overall outcome similarities reported in meta-analytic research. And just as some researchers have started to examine the principles of change that might underlie various

kinds of effective therapies, others have been studying the characteristics of therapists, clients, and therapy relationships in search of common features that might be associated with successful treatment (e.g., Norcross & Lambert, 2018). If they can determine what these common features are, perhaps they can be maximized to benefit clients in the future.

Research on Common or Nonspecific Factors in Therapy

In Chapter 6, we mentioned that the characteristics of therapists, clients, and the therapeutic alliance that forms between them can be important factors in the outcome of psychotherapy. Let's now consider what researchers have found about these factors and how they operate to produce their effects.

Therapist Variables. Are there therapist characteristics or behaviors —apart from adherence to a specific treatment method—that predict positive therapy outcomes? In an attempt to answer this question, a Task Force on Empirically Supported Therapy Relationships was created by APA Division 29 (Psychotherapy). After a thorough review and synthesis of the research literature, the task force summarized the results in a book entitled *Psychotherapy Relationships That Work*. This book, which has since been updated and expanded to include two volumes (Norcross & Lambert, 2019; Norcross & Wampold, 2019), found that characteristics of both the therapist and the therapeutic alliance are indeed associated with positive therapy outcomes (Norcross & Wampold, 2011). The two therapist variables found to be *demonstrably effective* were higher levels of empathy and encouraging feedback from clients. Three other factors were deemed *probably effective,* namely showing positive regard for the client, sharing the client's therapy goals, and having a sense of collaborating with the client.

The association between these factors and better outcomes appeared regardless of what specific treatment techniques or therapeutic approach was being used (Norcross, 2011). These results came as no surprise to therapists who favor the client-centered treatment approach advanced by Carl Rogers (see Chapters 2 and 8), who had long ago argued for the importance of

empathy and unconditional positive regard in setting the stage for client progress (Rogers, 1942). However, because virtually all of the evidence supporting the role of these therapist factors comes from correlational designs, not controlled experiments, we can't be sure whether they actually *cause* improvement (Cuijpers, Reijnders, & Huibers, 2019). If, for example, therapists come to feel emotionally closer to clients who are improving, therapist empathy and positive regard would follow client improvement rather than the other way around. Some studies have indeed found that treatment techniques drove improvement in symptoms, which then raised ratings of the quality of the alliance (e.g., Strunk, Brotman, & DeRubeis, 2010). Still, it seems likely that these therapist variables play at least some role in client improvement.

Client Variables. There are fewer studies, and less consensus, about which client variables are associated with better treatment outcomes, but certain client attitudes appear to be particularly helpful (see also our discussion in Chapter 6). The limited evidence available suggests the following conclusions, neither of which are particularly surprising:

1. Clients who, from the beginning, are open to treatment, more willing to disclose their thoughts and feelings, and less resistant tend to have better outcomes (Bucher, Suzuki, & Samuel, 2019; Kahn, Achter, & Shambaugh, 2001).

2. Clients who have strong expectations that the treatment will be successful tend to have better outcomes than those who do not expect success (Greenberg, Constantino, & Bruce, 2006).

Of course, client variables may interact with other factors to influence outcomes. For example, clients whose cultural values include the calm

acceptance of life's challenges might not do well in a therapy program where the emphasis is on confronting and overcoming stressors (Sue & Sue, 2016).

Relationship Variables. In Chapter 6, we discuss various views of the therapeutic relationship, and its measurement. Let's now consider the results of research investigating its influence on therapy outcome.

There are thousands of studies, reviews, and meta-analyses on the therapy relationship, or *therapeutic alliance*, and they are in general agreement that better relationships between therapists and clients of all ages are associated with better treatment outcomes (Baldwin & Imel, 2013; Horvath et al., 2011; Leibovich et al., 2019; Norcross, 2011; Norcross & Wampold, 2011; Shirk, Karver, & Brown, 2011). In the following brief excerpt, you can easily see the strength of a therapeutic relationship, and get an idea of how it can promote improvement:

THERAPIST: So, what is it like when you're feeling really down?

CLIENT: I get like I don't want to talk to anyone. I'm like get away, leave me alone. My Dad asks me how I'm doing and I just say nothing or walk away.

T: You just want some space. You don't want to be pushed.

C: Exactly.

T: In here, I'm going to ask you a lot about how you are feeling. If you feel like I'm pushing you, is it possible you will not want to talk with me?

C: I don't think that'll happen because you're not in my face. Talking gets my stress out. When I'm in a bad mood on the day of our meetings, I look forward to our talking… . it helps keep me going because I know you get me. (Shirk, Karver, & Brown, 2011, p.19).

As is the case for helpful therapist characteristics, certain client and relationship characteristics are associated with better therapy outcomes no matter which specific treatment technique or therapeutic approach is used (Norcross, 2011). Still, there is evidence for the value of customizing therapy and various aspects of the therapy relationship on the basis of individual client characteristics or behaviors. For example, in some studies, clients who are open to therapy tend to do better when there is a relatively structured treatment provided by a relatively directive therapist, whereas clients who are more resistant to therapy appear to do better when the therapist is not too directive and provides a treatment that promotes self-control (Norcross & Wampold, 2011).

Although there is no doubt that research shows an association between therapeutic alliance quality and treatment outcome, the strength of that association is generally modest (Baldwin et al., 2004). Do good therapeutic relationships actually cause better outcomes? Some researchers see a causal link, but others are not so sure. That is because few therapy-outcome studies take into account the timing of the alliance and the improvement. Just as therapist empathy could be the cause or the effect of client improvement, a good therapeutic alliance could develop as the result of client improvement, not as its cause (Kazdin, 2007). Indeed, some studies that have measured the quality of the therapeutic alliance and symptom change at multiple points during treatment suggest that a positive alliance follows symptom change, not vice versa (DeRubeis, Brotman, & Gibbons, 2005; DeRubeis & Feeley, 1990). Others have reached the opposite conclusion (Horvath et al., 2011; Norcross & Lambert, 2006).

Despite this mixed evidence, it is clear that specific treatment techniques and therapeutic relationships are both important in offering therapy that

works. Of course, we still need to understand the mechanisms through which effective treatments work—both in terms of specific treatment techniques and also in terms of common factors across all treatments based on therapist, client, and relationship variables (Ewbank et al., 2020; Kazdin & Blase, 2011; Prochaska, Norcross, & Saul, 2019). Clinical scientists are trying hard to accomplish this challenging goal.

In Review Results of Research on Individual Treatments

Summaries of Treatment Outcome	**Procedures Used**	**Conclusions**
Client satisfaction surveys	Non-random sample of posttreatment clients asked to rate the helpfulness of their therapy.	About 90% say therapy helped them, regardless of type of treatment received.
Box score reviews	Outcome studies are categorized as yielding positive or negative results.	Therapy is generally helpful, but results are mixed due to variability in study quality and categorization criteria.
Meta-analyses	Combines results of many studies to estimate the average effectiveness of treatment (effect size).	Estimates of therapy effectiveness generally range from medium to high. May be no significant overall differences across types of treatment when collapsed across disorders and populations, but, differences generally favor behavioral and cognitive behavioral

		therapies for certain disorders.
Empirically supported treatment (EST) lists	Clinicians and researchers review therapy-outcome literature and its quality.	Certain specific treatments are efficacious for certain categories of disorder.
Integration of evidence from controlled research, clinical experience and client needs and preferences	Combine EST lists with evidence supporting effectiveness of treatment in clinical practice.	The era of evidence-based practice is dawning, though not all clinicians are embracing it.
Common Factors in Successful Therapy Therapist characteristics Client characteristics Therapeutic relationship	Empathic, encourages client feedback, shows positive regard for client, shares client's treatment goals, collaborates with the client. Open to treatment, willing to self-disclose, not resistant, has high expectations for success. Strong alliance.	

Test Yourself

1. Client satisfaction surveys support the value of psychotherapy, but their results are not based on a __________sample of clients and are therefore not _________.

2. Box score reviews of therapy-outcome studies have been criticized because they do not take into account differences in the _________ of the

studies reviewed.

3. The results of meta-analyses of therapy outcomes have been criticized because their statistical methods and the way studies are combined may not be __________ enough to identify differences between different treatments for specific disorders.

You can find the answers in the Answer Key at the end of the book.

Results of Research on Other Modes of Intervention

Section Preview In this section, we summarize the results of outcome studies of group, couples, and family therapy; preventive interventions; and self-help modalities. We also consider the effectiveness of psychotropic medications in relation to psychological treatments.

Compared with research on individual therapies, there is less research evidence about the outcome of group, couple, and family therapies and self-help and preventive techniques. Still, available results suggest that, in general, these other formats are associated with benefits that are at least equal to those of individual treatment.

Findings on Group Therapy

Empirical evidence confirms that group therapy can be an effective form of treatment, especially when there is strong group cohesion and a strong therapeutic alliance (Burlingame & Baldwin, 2011). A number of different group therapy interventions have shown strong evidence of effectiveness, including supportive group therapy for schizophrenia and cognitive behavioral group treatment for depression (Drossel, 2009).

Clients with certain disorders may benefit especially from treatment in a group format, including those with social anxiety disorder (SAD). These clients, who typically experience strong fear of social performance situations and possible scrutiny by other people, appear to respond well to cognitive behavioral group therapy (CBGT), partly because the group situation lends itself to simulation of a wide variety of social interactions and constant exposure to social situations. Meta-analytic research has shown that CBGT has a moderate, but significant effect in the treatment of SAD compared with control conditions (Wersebe, Sijbrandij & Cuijpers, 2013).

Proponents of group therapy contend that evidence of its effectiveness will lead to its increased use because of the cost savings for clients and insurance companies.

Findings on Couples Therapy

Compared with no-treatment control groups, almost all forms of couples therapy appear to produce significant improvements in the couples' relationship satisfaction and psychological adjustment (Baucom et al., 2011). There is especially strong research support for behavioral couples therapy (BCT). One review of 30 studies found that 72% of treated couples were better off at the end of treatment than were couples who did not receive treatment (Shadish & Baldwin, 2005). A later review suggested that the same was true of 80% of treated couples (Gurman & Snyder, 2011). BCT for alcohol use disorder has been shown to be especially effective (Gurman & Snyder, 2011), and integrative behavioral couples therapy, which adds an acceptance-based approach to standard behavioral therapy techniques, also appears promising (McGinn, Benson, & Christensen, 2011; see Chapters 9 and 10 for more on acceptance-based treatments).

In emotion-focused couple therapy (EFCT; Johnson & Greenberg, 1985), the therapist and the clients examine patterns in the relationship and take steps to create a more secure bond, develop greater trust, and thus move the relationship in a healthier, more positive direction. A recent meta-analysis of 33 studies found that both BCT and EFCT showed moderate, but positive pre-to-posttreatment changes in relationship satisfaction (Rathgeber et al., 2018). Six months after treatment ended, both therapy approaches still showed a small, positive effect on relationship satisfaction but these gains were not maintained after 12 months.

Although the long-term effectiveness of couples therapy is unclear, there is some evidence that two of the key short-term factors in successful couples

therapy are communication training and the development of problem-solving skills (Oliver & Margolin, 2009). Still, the overall picture is not yet bright; we need to identify the mechanisms in couples therapy that work best with different types of clients and that promote more durable treatment gains (Gottman & Ryan, 2005; Snyder, Castellani, & Whisman, 2006).

Findings on Family Therapy

Families who complete a course of therapy together usually show significant improvements in communication patterns and in the behavior of the family member whose problems prompted therapy in the first place (Kaslow, 2011; Stanton, 2013). This outcome is typically reported for several kinds of identified clients and family problems. In one review of 19 studies, the average client whose family participated in therapy was better off than 76% of clients who experienced an alternative treatment, a minimal treatment, or no treatment (Markus, Lange, & Pettigrew, 1990). This review also found that although the effects of family therapy increased during the first year after treatment, these effects diminished sharply 18 months after the end of therapy.

Certain types of family therapy appear more successful than others. Behavioral and structural family therapies have received the strongest empirical support. Treatments such as behavioral parent training or parent management training (Briesmeister & Schaefer, 2007) and parent–child interaction therapy (Funderburk & Eyberg, 2011) are also considered effective practices. Another effective approach is behaviorally based family therapy, also known as multisystemic therapy, which has been used with diverse kinds of families, including those from disadvantaged backgrounds (Henggeler, 2011). The treatment is well-established for juvenile delinquents and/or adolescents showing social, emotional and behavioral problems, but as one recent meta-analysis found, the effects are not always strong for all juvenile clients (it works better for those under 15), or for all dimensions of their problems, including coping skills and adaptive thinking (van der Stouwe

et al., 2014). Family-based treatment for anorexia nervosa, family-focused therapy for bipolar disorder, and family psychoeducation for schizophrenia have reasonably strong research support (Kaslow, 2011).

As is the case for individual treatment, most of the strongest family therapy procedures include behavioral and psychoeducational components. These components have proven to be effective in specific populations (i.e., perinatal depression) and specific settings (i.e., pediatric primary care) where family dysfunction is commonly observed (Cluxton-Keller et al., 2015; Cluxton-Keller & Bruce, 2018).

Findings on Preventive Interventions

In Chapter 10, we describe a number of prevention programs that grew out of the community psychology movement. These programs are typically designed to modify social, economic, and environmental risk factors that lead to disorders or to strengthen positive qualities that can protect vulnerable individuals from developing disorders.

Large-scale, well-controlled studies have identified a number of effective prevention programs (Barrera & Sandler, 2006), including the following:

- Preventing aggression by teaching adolescents anger management and social problem–solving skills as they make the transition from elementary to middle school (Lochman & Wells, 2004).
- Preventing HIV infection by addressing informational, motivational, and behavioral skills competence related to safe-sex methods among inner-city high school students (Fisher et al., 2002).
- Preventing binge drinking on college students’ 21st birthday by giving personalized feedback of students’ intentions to drink moderately (Neighbors et al., 2009).
- Preventing substance abuse by children and adolescents by increasing parenting skills and strengthening healthy connections within families (Kumpfer & Alvarado, 2003).
- Preventing suicidal behaviors in adolescents by increasing discussion and knowledge about mental health, suicide prevention, and the

development of problem-solving skills and emotional intelligence (Wasserman et al., 2015).

In short, there are effective prevention programs for many mental health problems and there is renewed interest in changing communities to make them more consistent with the development of psychological well-being (Biglan et al., 2012).

Findings on Self-Help Resources and Self-Help Groups

The effects of self-help groups, apps, and internet resources are seldom evaluated empirically. Many troubled individuals who use self-help methods are convinced that these methods have value for them and thus see formal outcome research as unnecessary. Evaluation is further complicated because it is not clear who uses which resources and for what problems, especially when the resources are web based. PsyberGuide (https://psyberguide.org/) is a website offering information to consumers about which mental health apps have research support, but the majority of them remain untested.

There has been somewhat more research on using self-help books (i.e., bibliotherapy) and websites. It suggests that some of these resources can be effective for treating mild depression, eating disorders, gambling, anxiety, and mild alcohol abuse (Harwood & L'Abate, 2010), but because this research covers no more than 5% of self-help books available, we do not know whether and how well most of them work (Arkowitz & Lilienfeld, 2006).

Even when these resources appear to help, lack of controlled research leaves open the question of the mechanisms of change. In short, the effectiveness of self-help materials can vary substantially. The phrase *caveat emptor* ("buyer beware") is especially relevant when it comes to self-help resources given indications that some self-help programs produce harmful effects in at least some individuals (Rosen, 1987). A book called *Self-Help That Works: Resources to Improve Emotional Health and Strengthen Relationships* (Norcross et al., 2013) is a useful source of information.

Findings on the Combination of Psychotherapy and Medication

A number of studies have found that psychotherapy—particularly behavioral and cognitive behavioral treatment—can result in benefits that are greater and more enduring than drug treatments for anxiety disorders, depression, obsessive-compulsive disorder, posttraumatic stress disorder, and other problems in adults and children (e.g., Hollon, Stewart, & Strunk, 2006; Merz, Schwartzer, & Gerger, 2019; Skapinikas et al., 2016; Wang et al., 2017; see Figure 7.4). However, this is not the case for every kind of client and every kind of disorder. For example, one study found that adding antidepressant medication to a program of CBT did no better than CBT alone in treating adolescents with depression (Davey et al., 2019). And a meta-analysis found that medication was significantly more efficacious than psychotherapy for dysthymia (called persistent depressive disorder in DSM-5), whereas psychotherapy was significantly more efficacious than medication for OCD (Cuijpers et al., 2013b).

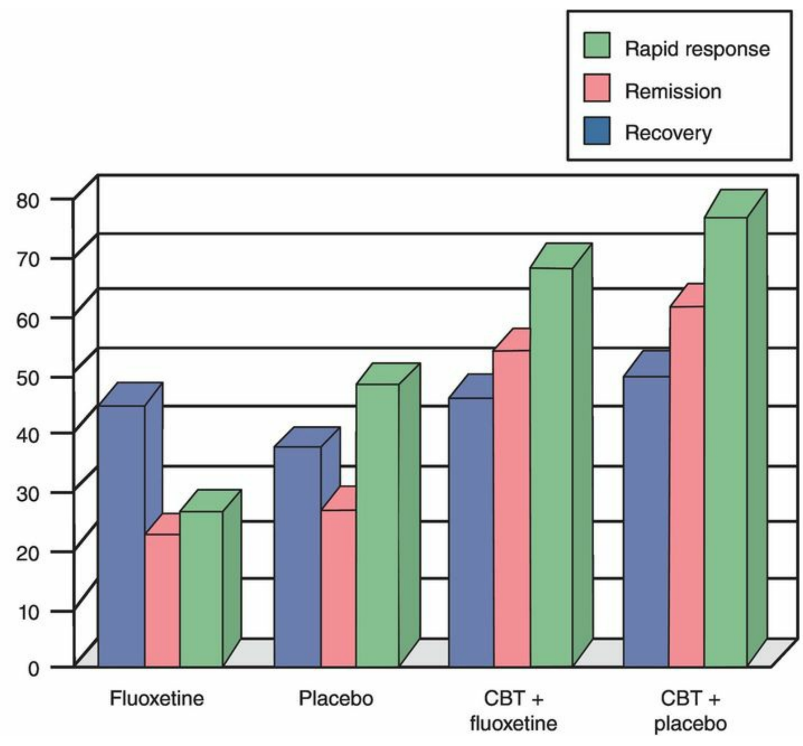

Figure 7.4 Results of a Randomized Controlled Trial Comparing Fluoxetine (Prozac), a Placebo, Cognitive Behavior Therapy (CBT) + Fluoxetine, and CBT + a Placebo for Binge Eating Disorder
The highest rates of recovery were associated with CBT with either real or placebo drugs. “Rapid response” means at least a 65% reduction in binge eating episodes by the fourth treatment week; “recovery” means less than one binge weekly for the past month; “remission” means zero binges for the past month.

(Source: Grilo, C. M., Masheb, R. M., & Wilson, G. T. (2006). Rapid response to treatment for binge eating disorder. *Journal of Consulting and Clinical Psychology*, *74*, 602–613.)

What about combining medications with psychotherapy? Some studies have found that a combined treatment did not do much better than either treatment alone for anxiety and depression (Hollon et al., 2005; Hollon, Stewart, & Strunk, 2006), but others—including three meta-analyses—have

found the combination significantly more effective in the treatment of depression, panic disorder, posttraumatic stress disorder, and OCD (e.g., Cuijpers et al., 2009, 2014; Merz, Schwartzer, & Gerger, 2019; Sammons, 2011). In the case of psychosis, there is some evidence that combining antipsychotic medication and cognitive behavior therapy is significantly more efficacious than CBT alone, but not significantly better than the antipsychotics alone (Morrison et al., 2018).

So combining medication and psychotherapy seems especially valuable for some disorders and for clients who do not respond to either treatment alone. The combined treatment may have a higher initial financial cost, but it can be significantly more cost-effective in the long run (Lynch et al., 2011). One study found, for example, that the addition of psychotherapy to a medication regimen for schizophrenia clients can reduce the need for subsequent inpatient admission, thus creating major cost savings (Karow et al., 2012). Adding medication to a psychotherapy regimen may sometimes be helpful, too, but not necessarily. There is evidence that when treating some anxiety problems, for instance, starting and then withdrawing medication can reduce the long-term benefits of cognitive behavior therapy (e.g., Barlow et al., 2000).

When it helps to combine drugs and psychotherapy is it because the effects of each are complementary or are these effects independent of each other? One review of the research literature (Cuijpers et al., 2014) suggests that the effects may be largely independent and additive, meaning that each may contribute about equally to combined treatment effects. The picture is still unclear, but with Gordon Paul's (1969) "ultimate question" in mind, researchers are increasing their efforts to determine for whom, when, and

how the combination of medication and psychotherapy works best (Craighead & Dunlop, 2014).

Even though there is strong evidence that some forms of psychotherapy alone are sufficient for the effective treatment of some disorders, many clients in psychotherapy for those disorders are also getting drugs. This is a cause for concern because these unnecessary drugs can have adverse side effects, and also because many clients prefer not to take drugs (Hazlett-Stevens et al., 2002; Zoellner et al., 2003). Thus, the increasing numbers of clients who are given only psychopharmacological options by their managed-care companies may not be receiving the services they prefer or the ones that are most helpful in the long term (Miller, 2013b). This situation highlights the need for researchers to identify valid predictors of which clients are most likely to benefit from psychotherapy alone, medication alone, or a combination of the two (Ross et al., 2019). These predictors would be vital guides for clinical decision-making by clinical scientists in psychology and medicine alike.

In Review Results of Research on Other Modes of Intervention

Treatment Format	Summary of Results
Group therapy	Can be effective for many disorders, especially when there is a strong therapeutic alliance and group cohesion.
Couples therapy	Most forms, especially behavioral couples therapy and emotion-focused couples therapy, are effective, but benefits may not be long lasting.
Family therapy	Behavioral versions are especially effective in the short-term; benefits tend to diminish over time.
Prevention programs	A number of programs are effective for preventing aggression, HIV infection, binge drinking, drug abuse, and suicide.
Self-help groups and resources	Minimal experimental research has been done; some people find self-help useful, but the effectiveness of self-help materials can vary substantially; little clear cause–effect data are available.
Combination of psychotherapy and medications	Combination can be better than either alone for some disorders, but not others.
Test Yourself	

1. Because many people are convinced that self-help methods work for them, they see formal evaluation of these methods as ____________.

2. Which types of family therapy have received the strongest empirical support?

3. When given a choice between medication or psychotherapy, many clients prefer _____.

You can find the answers in the Answer Key at the end of the book.

Issues and Concerns About Research on Psychotherapy

Section Preview In this section, we review a set of concerns about treatment research, including those regarding internal and external validity, and discuss how these concerns are being handled by researchers and clinicians.

We have described the within-subjects and between-subjects methods that clinical scientists use to test how well treatments work and pointed out that their work now focuses on employing both kinds of designs in randomized controlled trials. The primary goal of therapy-outcome researchers is to design experiments whose results have the highest possible levels of both internal and external validity. Recall that a study has high *internal validity* if the design allows the researcher to assert that observed changes in dependent variable(s) were caused by manipulated independent variable(s), not by some unknown, unintended, or uncontrolled confounding factors. Outcome studies have high *external validity* if their results are applicable, or generalizable, to clients, problems, and situations other than those included in the controlled experiment. When they meet this goal, the researchers can be more confident that their studies can serve as useful guides for choosing treatments and charting progress in individual cases (Comer & Kendall, 2013).

Concerns and Compromises in Therapy Research

But by now you’ve probably recognized that there is an inherent tradeoff in designing valid research on psychological treatments: To exert the experimental control necessary to maximize internal validity, researchers may be forced to study clients, therapists, problems, treatments, and treatment settings that may result in limited external validity. But if the researcher tries to maximize external validity by conducting research on clients in community treatment settings who may have a broader range of problems, the resulting lack of experimental control may compromise internal validity. Given this dilemma, it is important to consider the extent to which the results of well-controlled experiments can be used to draw conclusions about therapies being conducted in clinical practice (Comer & Kendall, 2013). At the same time, we must be wary of evaluative data derived from less well-controlled research in clinical settings. Indeed, any conclusions drawn from the results of any outcome study must be tempered by awareness of the compromises in research design and methods that were made in an effort to strike a reasonable balance between internal and external validity.

There are also concerns that randomized controlled trials focus only on comparing different treatments rather than on the common factors (such as therapeutic alliance) that are evident across treatment modalities. As we mentioned earlier, both nonspecific and common factors probably contribute to treatment effects (Ahn & Wampold, 2001). Depending on the disorder, the quality of the therapeutic alliance and other client and therapist factors can account for proportions of variance that are comparable to specific treatment techniques (Messer, 2006). Thus, focusing on specific treatment techniques

that work and therapeutic relationships that work is likely to be the best approach to maximizing outcomes (Nathan & Gorman, 2007; Norcross, 2011).

We have also pointed out that there is great concern over the use of *treatment manuals* in outcome research. This concern arose initially because many clinicians did not normally use them and were reluctant to deal with the restrictions that these structured manuals impose (Addis & Krasnow, 2000). Recent evidence suggests, however, that practicing clinicians have now become far more aware of treatment manuals and that many use them routinely (Safran, Abreu, Ogilvie, & DeMaria, 2011). For example, one study found that treatment manuals were being used by 35.9% of clinicians who treat clients with bulimia (Wallace & von Ranson, 2011). There is also evidence that after using treatment manuals, therapists come to view them more positively (Forbat, Black, & Dulgar, 2015). With such evidence in mind, researchers have tried to make the manuals even more user-friendly and flexible for practicing clinicians. The clinicians who are most likely to use treatment manuals today tend to be younger and to favor cognitive behavioral techniques. The growing use of these manuals is based in part on growing evidence that using them does not harm the therapeutic alliance and can actually help the therapeutic process (Langer, McLeod, & Weisz, 2011). Still, there is also some evidence that adhering *too* rigidly to manuals can damage the therapeutic alliance, and perhaps hamper client progress (Castonguay et al., 1996). So therapists should regard manuals as providing flexible guidelines, not strict blueprints to be followed on a robotic, line by line basis (Hamilton et al., 2008).

Treatment manuals may also help address concerns about how to make information about evidence-based practices available to clinicians and mental

health consumers alike. As described in more detail in Chapter 10, there is increasing interest among researchers today in *dissemination* of their research results to professionals and the public and in encouraging *implementation* of evidence-based techniques in the real world of clinical practice (Forman, Gaudiano, & Herbert, 2016; Frueh et al., 2012). Here are just a few examples:

- A popular series of treatment manuals and client workbooks has been developed by clinical researchers in conjunction with practicing clinicians. The series, called *Treatments That Work*, addresses a number of clinical problems, including anxiety, depression, alcohol use, couples distress, and chronic pain. The workbooks are user-friendly and provide step-by-step details on what works in therapy for these problems (Barlow, 2004).
- Information about evidence-based treatments for adults and children is being disseminated to clinicians and clients online by organizations such as the Society of Clinical Psychology (Division 12 of APA) and the Society of Clinical Child and Adolescent Psychology.
- Information about state-of-the-science evidence-based practices (including treatments that work and relationships that work) can also be found at a website called Evidence-Based Behavioral Practice.

The need for dissemination and implementation efforts is clear from surveys of practicing clinicians showing that most of them are not well informed about current research findings on psychotherapy (Allen, Gharagozloo, & Johnson, 2012; Boisvert & Faust, 2006), are not familiar with evidence-based

practices, and tend to assume that those practices are less valuable than they actually are in improving the quality of their clinical work (see Figure 7.5).

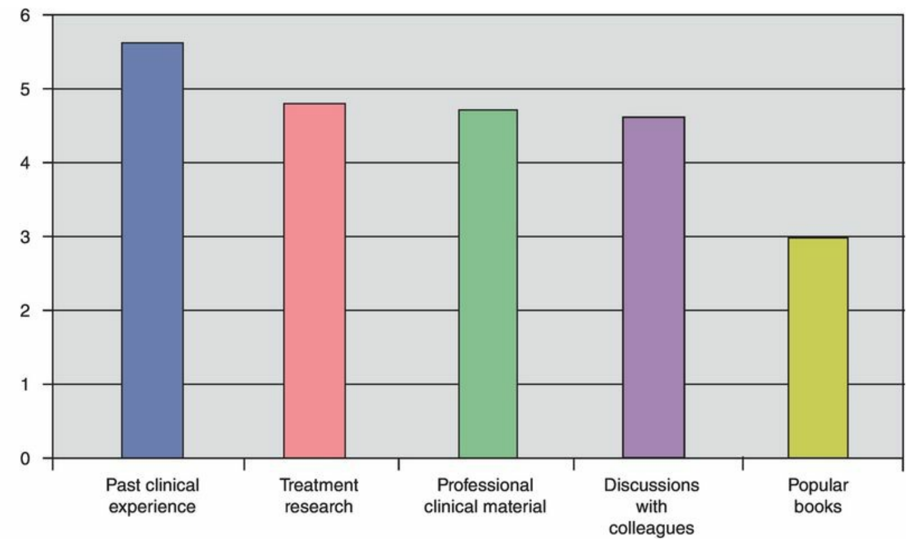

Figure 7.5 Resources Clinicians Use to Increase Therapy Skills and Effectiveness

Surveys suggest that the majority of practicing clinicians appear to rely more heavily on their own experience than on research findings or treatment manuals.

(Source: Stewart, R. E. & Chambless, D. L. (2007). Does psychotherapy research inform treatment decisions in private practice? *Journal of Clinical Psychology*, *63*, 267–281.)

Admittedly, it takes a lot of time to stay up to date with all the empirical advances in clinical psychology. One study estimated that it would take 627.5 hours each month to read all of the articles related to a particular clinical practice (Alper et al., 2004), so given that there are only 720 hours in a month, it is easy to understand why practicing clinicians don't try to master all the empirical knowledge pertinent to their area of specialization (Walker & London, 2007). Still, there are indications that clinicians are using and

benefiting from various electronic information dissemination efforts. One study of websites that describe evidence-based practices found that 60% of clinicians found online information to be helpful, that the information increased their awareness of evidence-based practices, and that the information increased their commitment to using such practices (Riley et al., 2007). This finding fits well with more recent research showing that factors such as flexibility in training strategies and technologies will be crucial in the future dissemination and implementation of evidence-based practices (Novins et al., 2013). The current focus on evidence-based practices brings together researchers and clinicians who are committed to their shared goals of finding and using treatments and relationships that offer the greatest benefits for their clients (Barlow et al., 2013).

In Review Issues and Concerns about Research on Psychotherapy

Topic	**Main Issue at Hand**
The internal–external validity dilemma	How best to design RCTs and other controlled research such that the cause–effect conclusions that can be drawn from the results will apply to the real world of clinical practice.
Treatment manuals	How best to influence practicing clinicians to become familiar enough with these manuals that they can make informed decisions about whether to use them with their clients.
Dissemination and implementation of research results	How best to make information about evidence-based treatments more readily available to clinicians.

Test Yourself

1. Results that are applicable, or generalizable, to clients, problems, and situations other than those included in the controlled outcome experiment are said to have high___________validity.

2. Treatments that work in large-scale studies conducted under controlled conditions are said to be____________; whereas those that are useful in the real-world of clinical service are said to be___________.

3. Clinical scientists are not only emphasizing the identification of treatments that work best for various disorders, but also the __________ of that information to practicing clinicians.

You can find the answers in the Answer Key at the end of the book.

Chapter Summary

Evaluative research on clinical interventions has focused mainly on the effects of various forms of individual psychological treatment. The goals of this research are to answer questions about the efficacy of specific treatments, the relative effectiveness of different treatments, the components of treatment responsible for improvement, the durability of treatment benefits, and the clinical significance of different therapies.

The main method for establishing a causal relationship between therapy and improvement is the controlled experiment in which the researcher makes systematic changes in certain factors (called independent variables) and then observes changes occurring in other factors (called dependent variables). In psychotherapy-outcome research, the independent variable is usually the type of therapy given, and the dependent variable is the change seen in clients. Within-subjects studies manipulate a treatment variable and observe its effects on the same client(s) at different points in time. Between-subjects studies randomly assign clients to different groups, each of which is exposed to differing treatments whose effects are compared. Over the years, therapy outcomes have been investigated and summarized via many techniques (including box scores, meta-analytic techniques, client satisfaction surveys, and randomized controlled trials). Currently, the bulk of the empirically supported, evidence-based treatments falls in the cognitive behavioral and behavioral categories. However, common and nonspecific factors including characteristics of the therapist (such as empathy and asking for client feedback), the client (such as openness and willingness to disclose), and the

therapist–client relationship (such as strong therapeutic alliance) are also associated with better outcomes. The extent to which these factors are the genuine causes of better outcomes is still unclear, however.

In addition to the promising treatments and common factors identified in individual therapy, a number of other modes of therapy have been shown to yield good outcomes. For example, group therapy seems especially promising when there is strong group cohesion and therapeutic alliance. Certain types of group therapy (such as supportive group therapy for schizophrenia and cognitive behavioral group treatment for depression) have received strong empirical support. Other modes of treatment, such as couples, family, preventive, self-help, and the combination of psychotherapy and medication have also shown promise for certain problems, though their effects are not always durable.

There are, however, a number of issues and concerns about psychotherapy research. There is no perfect treatment outcome study. If an outcome study is high on internal validity, the researcher can be confident that observed changes in clients were actually caused by treatment, not by uncontrolled confounding factors. An outcome study is high on external validity if its results are generalizable to clients, problems, and situations other than those included in the experiment. Thus, researchers must try to design outcome studies with the highest possible levels of both internal and external validity. Researchers are also working to disseminate research findings widely so that information about effective treatments can inform evidence-based practice by clinicians in the community. There is hope that the current focus on evidence-based practice will bring together the strengths of researchers and clinicians for the ultimate improvement of clients' well-being.

8

Psychoanalytic, Psychodynamic, and Humanistic Psychotherapies

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Contents

Psychoanalysis

Psychodynamic Psychotherapy

Interpersonal Psychotherapy

Humanistic Psychotherapy

Chapter Preview

In this and the next two chapters, we focus on specific approaches to psychotherapy. Therapy approaches, and variations of them, can be thought of as families whose members are related by certain shared concepts and practices. This chapter describes families of relationship- and emotion-focused therapies, whose members include psychoanalytic, psychodynamic and humanistic treatments. We begin with Freud's traditional psychoanalysis, which stresses the need for clients to develop insight into their primitive drives, unconscious conflicts, and patterns of relating. Next, we cover other psychodynamic approaches that share ideas with traditional psychoanalysis, including interpersonal therapy. We then describe humanistic treatments, including person-centered, Gestalt, and existential therapies. All of these emphasize each client's unique way of experiencing the world. Psychodynamic and humanistic treatments are considered relational approaches because they place strong emphasis on the role of the therapeutic relationship in treatment. To conclude the chapter, we tell you about a variety of other treatments that emphasize the role of emotion and interpersonal relationships in helping clients overcome psychological problems.

Psychoanalysis

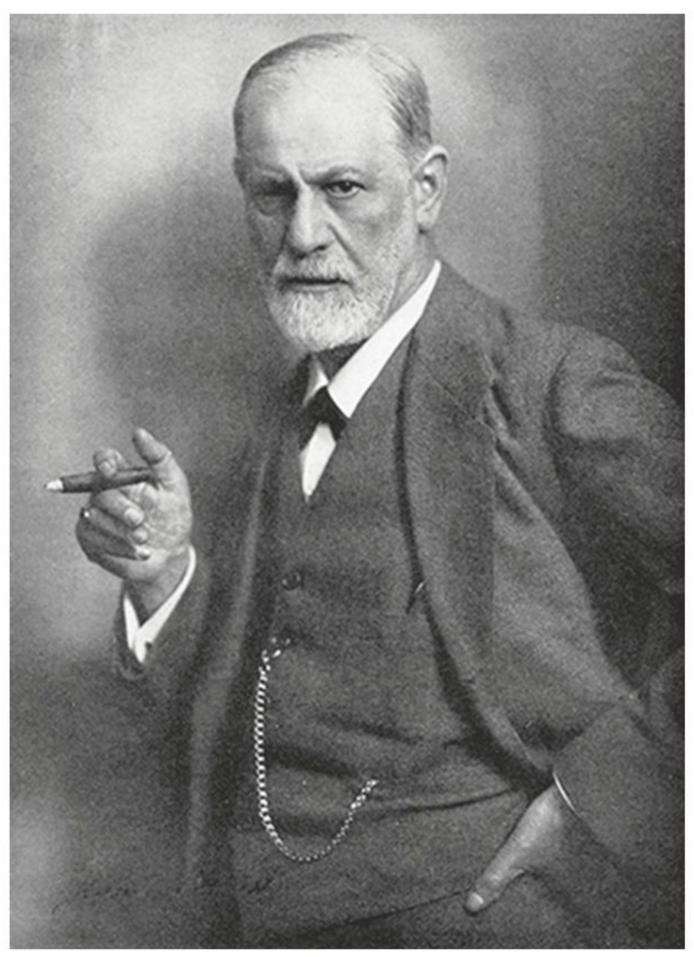
Section Preview In this section we describe traditional psychoanalysis, a theory that links personality characteristics and psychological disorders to unconscious conflicts stemming from early childhood relationships and to psychological defenses against the anxiety created by those conflicts. We then review psychoanalytic treatment methods, in which therapists look for signs of conflicts and defenses in clients' behavior, including reactions to the therapist that reflect early relationships with their parents. Focusing on this transference of previous relationship patterns onto the therapeutic relationship helps psychoanalytic therapists interpret the meaning of their clients' maladaptive behaviors and better understand the unconscious factors that motivate them. Proposing these interpretations is thought to help clients gain insight into the historically grounded conflicts and behavior patterns related to their symptoms. The section ends with a summary of research suggesting that scientific support for psychoanalytic therapy methods is not as strong as it is for those described later in this book, but we encourage you to keep an open mind as you read about the broad outlines of psychoanalysis as Freud proposed it.

If you have read Chapter 2, you know that Sigmund Freud (1856–1939) was a Viennese neurologist who founded the psychodynamic approach to psychology. This approach grew out of his attempts to treat patients who reported physical symptoms for which no obvious organic cause could be found. Some, for example, complained of paralysis that affected their entire

right hand but not their right arm. Others suffered paralysis of the legs during the day, and yet walked in their sleep.

Freud's Theory of Personality and Psychopathology

In trying to understand these patients, Freud applied centuries-old philosophical ideas about multiple levels of human consciousness. He described mental life as occurring partly at a *conscious* level of full awareness; partly at a *preconscious* level, about which we can become aware by shifting our attention, and partly and most importantly, at an *unconscious* level, which we cannot experience without the use of special therapy techniques. This continuum from unconscious, to preconscious, to conscious is called the *topographical model* of the mind, and it is fundamental to understanding Freud's view of personality. As we describe in Chapter 2, Freud saw personality developing through the interaction of powerful and often conflicting forces within each person, some of which are conscious but most of which are not. In Freud's system, those forces are represented as the id, the ego, and the superego. When they are in severe and prolonged conflict, he said, the result is neurosis.



Sigmund Freud (1856–1939)
Freud's psychoanalytic theory of personality and psychological disorder highlighted the role of unconscious psychological conflicts and led to the development of psychotherapy methods designed to resolve those conflicts.

(Source: Universal Images Group/Universal Images Group Editorial/Getty Images.)

The *id* is the source of our most fundamental biological drives, especially sexual/sensual and aggressive ones. Freud's medical training led him to see these drives as present at birth, meaning that even infants are sexual and aggressive beings. He famously claimed that by the age of 3 or 4

years, children come to desire their opposite-sex parent and want to eliminate their same-sex parent, who is seen as a rival for the opposite-sex parent's affection. (The concept of infant sexuality was by far the most controversial of Freud's ideas, and it accounted for much of the opposition to his theory that we describe in Chapter 2.) Freud recognized that id-based drives had to be kept in check somehow if civilized society is to survive, and he proposed that this counterbalancing force is provided by the *superego,* the part of the personality that incorporates social and behavioral norms from our parents, family, and culture. The superego contains both our *conscience*, which punishes us with guilt when we do things that are morally wrong, and our *ego ideal*, which reflects how we would ideally like to be and which rewards us with pride when we do things that are morally right. The id and the superego are often in conflict: the id seeks to discharge tension by expressing sexual or aggressive impulses, whereas the superego seeks to inhibit those impulses and dictate more socially appropriate behavior. The *ego* is the part of the personality that tries to mediate between the conflicting demands of the id and superego while also recognizing and responding to external realities. Together, these three elements—id, ego, and superego—form a *structural model* of personality (see Figure 8.1).

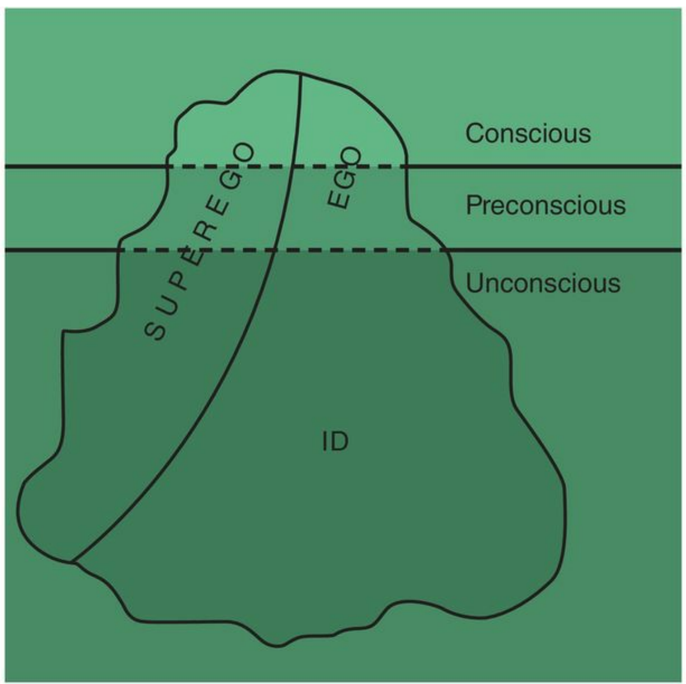


Figure 8.1 The Psychoanalytic Model of the Mind
Freud argued that most of the dynamic interactions among three main elements of personality occur out of awareness, in the preconscious and unconscious. This structural model of the mind reflects Freud's background as a neurologist and the influence of Pierre Paul Broca (1861, 1865), a French physician and anatomist who had pioneered research on the idea that different parts of the brain serve different functions.

Freud proposed that dynamic, tension-filled conflict occurs continuously in all of us, as can be seen in everyday examples of conflicting urges. Recall the last time you sat through a boring class. One part of you probably wanted to get up and leave, perhaps to do something more interesting. At the same time, another part might have urged you to stay and try paying closer attention, reminding you that you need the class to graduate, and that you should be more mature, learn to delay gratification, and so on. You were probably painfully aware of this conflict, but Freud said that our most

important and problematic intrapsychic (internal) battles usually occur unconsciously, outside of awareness. To Freud, then, much of mental life involves constant turmoil among competing parts of the personality. This conflict, he maintained, is the inevitable price we pay for living in a civilization that imposes restrictions on what we can and cannot do. The symptoms of psychological disorders, he said, are reflections of this turmoil, of the spilling over of intrapsychic conflicts, and of the person's efforts to control the anxiety stemming from them.

Defense Mechanisms. Suppose, for example, that a child feels very angry at a parent but fears that expressing anger would be punished (often a realistic fear, especially if the parent has been verbally or physically violent in the past). For this child, experiencing anger and id-driven impulses to be aggressive would create anxiety. According to psychoanalytic theory, the ego would typically deal with this situation by activating psychological **defense mechanisms** to keep anger-related anxiety from reaching consciousness, where it might interfere with the child's functioning (see Table 8.1).

Table 8.1 Psychological Defense Mechanisms, Ordered Roughly from Least to Most Mature

Freud saw defense mechanisms as unconscious mental strategies or routines that the ego employs to ward off the anxiety produced by intrapsychic conflicts.

Mechanism	Description	Example from the Jackson family
Denial	Being unable to recognize or acknowledge threatening	Despite drinking to excess nearly every day and recently losing his

	experiences	job, Rachel Jackson's father, James, will not recognize that he has a drinking problem.
Repression	Anxiety-provoking thoughts and memories disappear into the unconscious ("motivated forgetting")	Rachel has no recollection of the day when she was 6 and saw her father slap her mother during an argument.
Regression	Retreating to coping strategies characteristic of earlier stages of development	During a period when their parents were having many violent arguments, Rachel's 12-year-old brother Jamal asks his mother to lay out his school clothes for him, and tuck him in and read to him before bed "like you used to."
Projection	Attributing one's own negative motives and impulses to others	When her husband forgot her birthday, Rachel's mother, Lena, perceives him as hurt and angry.
Reaction formation	Adopting thoughts and behaviors that are the opposite of one's own	James Jackson had long hated the boss who eventually fired him, but he always went out of his way to defend the boss against criticism by other employees.

Displacement	Directing pent-up impulses toward a safer substitute rather than the target that aroused the impulses	Angry and embarrassed after being teased about her weight by one of her new friends, Rachel screams at her mother for asking her to set the dinner table.
Rationalization	Providing socially appropriate, but untrue, explanations for one's undesirable behavior	While on her crash diet, Rachel tells herself that she avoids fried foods because they don't taste good to her.
Intellectualization	Dealing with upsetting experiences in an overly logical manner, usually with reference to some non-emotional explanatory theory or scientific principle	Asked by a family therapist to describe life since he lost his job, James Jackson says that he has been learning a lot about the macroeconomic theories that led to his company's decision to downsize the department where he worked.
Compensation	Coping with feelings of inferiority in one area by working to become superior in another area	Rachel's younger sister, Janelle, has never been accepted by the "popular" group at school, but has become a standout player on the basketball team.
Sublimation	Channeling the	As thoughts about leaving

	expression of unacceptable impulses into more socially acceptable activities	her husband become more frequent, Rachel’s mother begins writing a romance novel about a happy couple’s life on a tropical island.

Defense mechanisms

Unconscious mental strategies designed to keep anxiety-provoking material from reaching consciousness.

Anna Freud (1895–1982)

It was Sigmund Freud's daughter, Anna, who most fully developed his ideas about defense mechanisms. In her book, *Ego and the Mechanisms of Defense* (A. Freud, 1936/1966), she categorized and described them and stressed their importance both in everyday life and in psychoanalytic treatment. She also proposed psychoanalytic theories of the development of psychological disorders during childhood (Fonagy & Target, 2003).

(Source: Imagno/Hulton Archive/Getty Images.)

According to Freud, moderate use of defense mechanisms can be useful in everyday life, but they are not necessarily successful or even adaptive. People who habitually use denial, repression, projection, or other defense mechanisms may experience temporary protection from anxiety, but may distort reality in the process and, over time, jeopardize their interpersonal relationships. Suppose, for example, that the anger-fearing child we mentioned earlier continues to use unconscious defense mechanisms to prevent awareness of angry feelings. In adulthood, this person may be unable to experience and express strong negative emotions. So hostile feelings towards a supervisor might create the perception that the supervisor is hostile (projection), or result in efforts to be extremely nice to the supervisor (reaction formation). Whatever the specifics, these attempts to deal with an anxiety-producing conflict are seen as superficial evidence of childhood-based emotional conflicts that lie beneath the surface of consciousness.

Foundations of Psychoanalytic Therapy

Freud's theories about personality and its development served as the basis for the goals and methods of psychoanalysis. These methods evolved as he attempted to treat patients in his medical practice who displayed paralysis, amnesia, blindness, numbness, inability to speak, and other physical symptoms for which no physical cause could be found. These patients were called *hysterics* or *neurotics,* and in Freud's day, standard treatments included wet packs and baths or electrically generated heat. Freud believed that any benefits that these methods provided came about through suggestion, so he began experimenting with techniques that maximized suggestion, especially the hypnotic methods that, as we describe in Chapter 2, he had seen demonstrated by the French neurologist Jean-Martin Charcot.

Around 1890, Freud began to combine hypnosis with a new technique called the *cathartic (*pronounced "kah-THAR-tick") *method,* which he learned from his mentor, neurologist Joseph Breuer. Breuer had stumbled on this technique while attempting to relieve the hysterical symptoms of a patient known as Anna O. Anna's symptoms included headaches, a severe cough, neck and arm paralyses, and other physical problems; they had begun while she was caring for her seriously ill father and had intensified following his death. She began to display extremes of mood that ranged from agitation and hallucinations during the day to calm, trancelike states in the evening. Breuer was struck by the fact that these "trances" resembled hypnosis. Breuer discovered that if, while in this hypnotic-like state, Anna was asked to describe the details of her hallucinations, during the following late-night hours she would enjoy a period of almost normal tranquility and mental

clarity. Anna came to refer to the process of describing her hallucinations as the "talking cure" or "chimney sweeping" (Fancher, 1973; Gay, 1998).

This talking cure did not eliminate Anna's daytime disorders, however, and new neurotic symptoms began to appear. It was while attempting to cure one of these—anxiety about drinking liquids—that Breuer made the discovery that would start Freud on the road to what eventually became known as *psychoanalysis*. During one of Anna's hypnotic states, she described an Englishwoman whom she did not like, and who had a dog that Anna particularly despised. Anna said that on one occasion she entered the woman's home and saw the dog drinking water from a glass. Anna was filled with strong feelings of disgust, but the need to be polite kept her from expressing them. It was while telling Breuer this story that she finally permitted herself to fully express her negative feelings about it. "When she emerged from the trance, she immediately asked for a glass of water, which she drank without the slightest difficulty" (Fancher, 1973, p. 49).

Removal of Anna's fear of drinking was apparently brought about by her vivid recollection of a forgotten event while in a trance. It occurred to Breuer that Anna's other hysterical symptoms might be caused by forgotten memories and that recalling them might help to cure her. Indeed, he found that "whenever he could induce Anna to recall those unpleasant scenes and, more importantly, to *express the emotions* they had caused her to feel, the symptoms would disappear (Fancher, 1973, pp. 49–50; italics added).

Freud, too, found the cathartic method successful, but not all his patients were hypnotizable. To help these people gain *conscious* recognition of emotional memories, he instead asked them to lie back on a couch, relax, and describe whatever thoughts, feelings, or memories came spontaneously to mind. This procedure became known as **free association**, a mainstay among

the psychoanalytic techniques we will describe later. Freud also began to pay attention to his patients' dreams. He speculated that dreams might represent fantasies and wishes, including socially unacceptable ones, that patients' psychological defenses keep out of awareness during the day, but that might appear—perhaps in disguised form—when those defenses are lowered during sleep. He suggested that, like dreams, hysterical symptoms could also be based on unconscious wishes and fantasies, not just on memories of real events. Perhaps, he thought, a patient's "memory" of childhood sexual abuse by a parent might actually be a *fantasy* or *wish* about sexual intimacy with that parent. It is now clear that, even in Freud's day, there were all too many real cases of sexual abuse (DeMause, 1987), but his speculation nevertheless led him to alter his approach.

Free Association
Saying whatever comes to mind, without censorship, to provide clues to unconscious memories, impulses and fantasies.

As a result, **psychoanalysis** and the psychoanalytic treatment of neurosis, shifted from the recovery of memories to the broader exploration of the patient's unconscious thoughts, including wishes and fantasies related to sexual longings. Many forms of psychotherapy grew out of Freud's treatment approach, and almost all of them reflect one or more of his basic ideas, including an emphasis on (a) searching for relationships between a person's developmental history and current problems, (b) blockages or dissociations in

self-awareness as causes of psychological problems, (c) talking as an approach to treatment, and (d) the importance of the therapeutic relationship.

Psychoanalysis
A method of psychotherapy that seeks to help clients gain insight into, and work through, unconscious thoughts and emotions presumed to cause psychological problems.

Transference and Countertransference. According to Freud, one of the psychoanalyst's main responsibilities is to understand the origins and meaning of clients' symptoms and help clients to do the same. This task is made easier, he said, by clients' tendency to repeat patterns of behavior, especially unconsciously motivated behavior. Specifically, Freud claimed that a client's maladaptive relationship patterns and problematic defense mechanisms will eventually appear in the therapy relationship. So, when clients expressed dependency, hostility, or even love toward him, Freud saw these behaviors and emotions as reflecting an unconscious process in which childhood feelings and conflicts about parents and other significant people were being transferred to the therapist. Analysis of this **transference**, this "new edition" of the client's childhood conflicts and current problems, became an essential psychoanalytic method (Hinze, 2015). Freud believed that focusing on the transference allows patients to see how old conflicts haunt their lives and helps them resolve these conflicts.

Transference
A process in which a client's typical relationship patterns and defense mechanisms appear in the therapy relationship.

Early Attachment Matters
Some of the interaction patterns and defense mechanisms that Freud saw being transferred to the therapy relationship were established when, as helpless infants, clients interacted with parents or other caregivers in ways that created anxiety, distrust, anger, or other emotions that interfered with secure attachments. There is growing evidence that such negative early experiences can even shape the developing nervous system in ways that enhance vulnerability to psychological disorders (e.g., Tierney & Nelson, 2009).

(Source: Ariel Skelley/DigitalVision/Getty Images.)

Of course, clients are not the only ones whose current relationships are colored by those of the past. Therapists are affected by transference patterns, too. When therapists' reactions toward clients are based on the therapist's

personal history and conflicts, those reactions are called *countertransference* (e.g., Connery & Murdock, 2019). Countertransference can impair the progress of therapy if therapists begin to distort the therapeutic interaction on the basis of their own conflicts and defenses. The inevitability of countertransference reactions is one reason many traditional psychoanalytically oriented clinicians believe that therapists themselves should undergo psychoanalysis. Their assumption is that if therapists understand and work through their own conflicts, those conflicts will be less likely to interfere with their treatment of clients. This is why trainees in psychoanalytic institutes today normally participate as clients in training analysis several times a week.

Psychic Determinism. In psychoanalysis, slips of the tongue ("Freudian slips") and other unexpected verbal associations are presumed to be psychologically meaningful, as are mental images, failures of memory, and a variety of other experiences. If a client suddenly remembers something that seems trivial or unrelated to the topic of discussion during a therapy session (e.g., a family vacation taken when he was 6, or the color of her mother's favorite dress), the therapist will probably assume that there is a significant reason that this material "popped into" the client's head. By asking the client to elaborate on, rather than ignore the material, the therapist looks for clues that might reveal an unconscious meaning behind the connection. Freud believed that associations among memories, impressions, and experiences in a client's mind are not random, but are determined by underlying unconscious processes. This idea, called *psychic determinism*, is a core assumption of psychoanalysis that underlies most if not all psychoanalytic methods.

Resistance. As psychoanalytic therapy progresses toward a deeper

understanding of the client's core unconscious conflicts, the client may begin to experience increasing anxiety. This anxiety may be reflected in "forgetting" appointments, experiencing panic, becoming overly intellectual and emotionally detached, disagreeing with the therapist's speculations about the causes of the client's problems, or engaging in other activities that appear to take the focus away from important conflicts. Psychoanalysts expect these and other forms of **resistance**, and like transference, resistance is seen as a reenactment of earlier patterns that serve as targets of treatment (Gabbard, 2010).

Resistance
A process in which clients behave in ways that interfere with the psychoanalytic treatment process.

Interpretation, Working Through, and Insight. Psychoanalysts offer emotional support as clients begin to discover their long-hidden unconscious impulses, fantasies, and conflicts. To help the process along, they make remarks about how clients' current thoughts, feelings, problems, and experiences might be connected to underlying causal conflicts. These remarks, or *interpretations*, provide a way to point out how the past might be intruding on the present. Interpretations can be based on what a client says or does during therapy sessions, or on reports of the client's experiences between sessions.

Optimal psychoanalytic interpretations are related to transference reactions that can be linked to the client's current difficulties (such as in a romantic relationship), to intrapsychic conflicts from the past, or both. These interpretations are presented not as conclusions but as hypotheses to be considered by the client; ideally, they pave the way for therapeutic progress. If an interpretation makes cognitive and emotional sense to the client—that is, if it is accurate *and* the client is ready to process it—it may lead to **insight**, or seeing a particular behavior pattern or problem in a new way.

Insight

A client's conscious awareness of the underlying causes of psychological problems.

In psychoanalysis, insight is the basic requirement for, and the beginning of, positive change, but insight alone is not enough. The client must also be encouraged to discover the many ways in which newly discovered unconscious elements continue to motivate maladaptive thinking and problematic behavior in everyday life. This process, called **working through** their insights, helps clients to develop a broader understanding of their problems, psychological makeup, and ways of relating to others.

Working through

Fully exploring the implications of insights gained in psychoanalysis.

Freud originally proposed that the goal of psychoanalysis was to make the unconscious conscious, but he later added another goal, namely to replace unconscious id processes with conscious ego processes (Wolitzky, 2011). According to Freud, when patients understand the real, often unconscious, reasons they act in maladaptive ways and see that those reasons are no longer valid, they will not have to continue behaving in those ways.

So, the main goals of psychoanalytic treatment are to help clients: (a) gain conscious and emotional *insight* into the underlying causes of their problems; (b) *work through,* or fully explore, the implications of those insights for everyday life; and (c) strengthen the ego's control over the id and the superego and thereby bolster clients' mastery over their sources of conflict. Freud saw working through as particularly important because clients need to understand how pervasive their unconscious conflicts and defenses are if they are to be prevented from returning as new symptoms. It would do little good for a client to finally recognize the unconscious anger she felt towards her mother in childhood if this insight doesn't help her to understand, for example, that she now deals with other women as if they were her mother and that her problems in relation to these women are based on unconscious hostility and attempts to defend against it. In short, insight provides the outline of a patient's story; working through fills in the details.

Reaching the ambitious goals set by classical psychoanalysis involves dissecting and gradually reconstructing the client's personality. This process

requires a lot of time. In classical Freudian psychoanalysis, four or five sessions each week are standard, and treatment can last for several years, or even decades in some cases. Psychoanalytic psychotherapy, a modified form of psychoanalysis, is often shorter in duration (Wolitzky, 2011). With fees generally well in excess of $150 per hour, the process is expensive.

A Case Example of Psychoanalysis

Let's suppose that, by taking advantage of a fee discount available through the hospital where she works as a nurse, Rachel Jackson's mother, Lena, decides to enter psychoanalysis. As described in Chapter 1, Lena has been struggling for over a year with feelings of exhaustion, anxiety, and depression related to Rachel's difficulties at school, her husband James's depression and disengagement, the need to cope with her elderly mother's increasingly serious health problems, and the stress of running a somewhat chaotic household.

What we did not mention is that over the past 3 months Lena has been experiencing attacks of intense anxiety, accompanied by rapid heart rate, sweating, dizziness, and other frightening physical symptoms. She had had one such panic attack while in nursing school 20 years ago, but she had almost forgotten about it until the weekend when she attended a continuing medical education course in a city about 200 miles from her home. That one came in her hotel room after dinner on Friday evening. As she lay down to sleep, she realized that her heartbeat was faster than usual. It soon accelerated to an uncontrollable pounding, and she began to sweat and have difficulty breathing. She tried to get out of bed but had to lay back down for fear that she would faint and injure herself in a fall. Rolling sideways, she was able to reach her cell phone and call 911. By the time Lena arrived at the emergency room, her symptoms had subsided, but she still felt shaky and anxious. A number of medical tests confirmed that she had indeed experienced a panic attack, not a heart attack. Since that weekend, she has experienced a number of similar episodes: "one at home, two at work, one while grocery shopping,

and one while driving.” She said, “They hit me out of the blue. They’re terrible, terrifying … and embarrassing.” Concern about if and when another attack might come has only added to her worries.

Lena’s feelings of sadness and bouts of depression came about more gradually. Even before her husband lost his job more than a year ago, she had occasionally felt lost and unsure about whether she had made the right choice in marrying and immediately starting a family. She was not even sure that she loved her husband, or if he loved her. She had always regarded him as a good man who was committed to his job—perhaps too committed—but she had noticed his interest in her waning in favor of spending time drinking with his friends from work. Now that he was unemployed, he virtually ignored her and their sexual relationship had all but vanished.

Despite the fact that she was valued at work—she had been promoted and given raises twice in the last 2 years—Lena often felt frustrated and useless, especially when bureaucratic paperwork and regulations interfered with her ability to deliver what she saw as high-quality patient care. These episodes of feeling down and unfulfilled had increased prior to her seeking treatment.

History and Case Formulation. Dr. Cynthia Leon, the psychologist Lena consulted about Rachel’s problems, referred her to Dr. Albert Kim (not his real name), a local psychoanalyst in private practice. Like most therapists, Dr. Kim begins by conducting a clinical assessment on which to build a case formulation (or basic understanding) of Lena and her life. And like most traditional psychoanalysts, he does not use structured assessment instruments such as the MMPI-2 or the PAI described in Chapter 5. Although some analysts do use such instruments, especially if they want to make a formal diagnosis, Dr. Kim bases his assessment on several interview sessions and the

results of unstructured (projective) tests such as the Rorschach, also described in Chapter 5.

As you can see in the psychoanalytically oriented case study outline presented in Chapter 3, Dr. Kim would be especially interested in the following kinds of information about Lena: (a) historical data such as family and developmental history (to identify information related to early conflicts or trauma); (b) mental status, level of distress, ego strengths and deficits, and "psychological mindedness" (to assess intellectual and emotional ability to engage in psychoanalytic treatment); and (c) defense mechanisms, themes, or patterns of attachment difficulties in interpersonal relationships (to identify transference patterns). He learns that Lena has one sister, and that her father, Adomas, had been a small-town physician before immigrating with his wife to the United States from Lithuania 2 years before Lena was born. He abandoned the family when Lena was 14, and his departure was partly a relief, as Lena had witnessed numerous parental fights in which her mother, Danutė, accused her hard-drinking father of being unfaithful. It also brought difficulties. With only limited English language skills, Danutė was forced to take poorly paid jobs and was barely able to make ends meet. She never remarried, but had a series of boyfriends, none of whom left any lasting impression on Lena.

Despite the family conflicts, Lena's father was an important figure in her childhood. She described him as "dashing," outgoing, and free-spirited —though also often quite drunk. Particularly significant were Lena's memories of him walking around the house in his underwear, tickling her and teasing her about being ugly. This behavior continued as Lena approached early adolescence. His pinching of her buttocks and her developing breasts brought her great embarrassment. She said there were no other forms of

sexual abuse, but reported strong anger about how his callous behaviors had hurt her self-esteem.

Lena had several boyfriends in high school and college. She said that she was attracted to the rebellious type, but at the same time felt that these young men were not smart enough for her and the relationships typically did not last more than a few months. She met her husband James when they were both 24 and she felt that he would be a more stable partner. His intelligence and sense of humor impressed her; they married the following year, and Rachel was born a year later.

Free Association. Following the assessment and case formulation phase, Dr. Kim explains to Lena that psychoanalysis requires following what analysts call the *fundamental rule*: She must say everything that comes to her mind without editing or censoring it. This *free association* process is crucial because, as we mentioned earlier, Freud believed that it helps clients to recover memories and reveal unconscious impulses and fantasies that eventually lead to useful insights. This process does not usually occur quickly. It is far more common that the unconscious sources of a client's current problems are revealed only gradually and indirectly in the form of memories, feelings, wishes, and impressions arising through patterns of free association. It is the therapist's task to try to make sense of these emerging bits and pieces, some of which might seem unrelated and even irrelevant.

During one therapy session, for example, Lena described her reaction to a man she met at that weekend continuing education course. "He was a jerk. I guess he thought he was hot stuff. I wondered if he was coming on to me, but I think he was like that with several women. Shameless. Greasy. I don't know why he bothered me so. I didn't even really get to know him." After a few moments of silence, she said, "I don't know why I thought of this, but I just

remembered standing in our bathroom when I was growing up, holding my father's comb."

The fact that thoughts about meeting a man at a medical course led to memories about holding her father's comb could have significance. In fact, psychoanalysts assume that it does. In Lena's case, it could mean that the characteristics of the man she met there reminded her of her father (e.g., greasy black hair, inappropriately flirtatious with women). Dr. Kim would no doubt ask Lena to consider the possible connections. One way of doing so would be to encourage her to engage in further free association about the man, the comb, and her father.

As treatment continued, Dr. Kim formed a tentative hypothesis about the origins of her problems. He considered her depression to be a symptom of her unsuccessful attempts to cope with the unconscious conflicts that affected her adult relationships. He speculated, too, that her panic attacks were related to concerns about intimacy, sexuality, and abandonment.

The Role of the Therapist. As in other forms of psychotherapy, the focus of psychoanalytic treatment is always on the client, but psychoanalysts have a particular way of keeping that focus. They are to maintain an "analytic incognito," meaning that—like someone whose personal identity is unknown—they reveal little or nothing about themselves during the course of psychotherapy. The therapist's likes and dislikes, problems, hopes, and so on, remain unknown to the client. If clients ask personal questions, the therapist usually reminds them that the session is for their benefit and that although the exchange of personal information is appropriate in other circumstances, it does not benefit psychoanalysis. In other words, the therapist remains purposely opaque, much like a blank wall, so that clients can be free to *project* onto the therapist the attributes and motives that are unconsciously

associated with parents and other important people in their lives. So, at various times, the client may see the therapist as a loving caregiver, a vengeful father, a seductive mother, a jealous lover, or the like. The therapist may also explore, and perhaps propose interpretations of, the motives behind the client's desire to know more about the therapist. Doing so often reveals transference-related material to be analyzed further. The analytic incognito is facilitated by the typical psychoanalytic office arrangements; the client normally lies on a couch and the therapist sits in a chair nearby, but largely out of sight. This configuration makes it easier for clients to focus their attention inward rather than on facial expressions or other visual cues from the therapist (Wolitzky, 2011).

Of course, remaining neutral does not mean that the psychoanalyst should be cold and unresponsive. Well-trained psychoanalysts understand the importance of creating emotional safety in the therapeutic relationship, so in working with Lena, Dr. Kim's comments are frequently empathic, supportive, and reflective (Borden, 2009; Gabbard, 2010; Gastelum, Douglas, & Cabaniss, 2013). He may use direct questions or encouraging phrases to help her more deeply explore her perceptions, emotions, and motivations. His interpretations, when they occur, can range from open-ended remarks (e.g., "I wonder if that seems familiar to you.") to more direct hypotheses about the meaning of patterns in current and past conflicts (e.g., "Have you considered that your supervisor might remind you of your mom in some ways?").

Analysis of Everyday Behavior. Psychoanalysts consider clients' reports of activities outside of treatment to be at least as important as the things clients say and do during treatment sessions. They try to maintain evenly divided or "free-floating" attention to trivial as well as momentous events, to purposeful acts and accidental happenings, to body language as

well as spoken language. So Dr. Kim will be interested in Lena's mistakes in speaking or writing—the "Freudian slips" we mentioned earlier—as well as examples of minor accidents, memory losses, and humorous comments as especially important sources of unconscious material.

Analysis of Dreams. Because unconscious material is believed to be closer to the surface in dreams than during waking consciousness, psychoanalysts tend to attach great importance to them. Lena's description of a dream—in which she is running through the woods and suddenly falls into a lake—reveals its *manifest content* or obvious features. Manifest content often contains features associated with the dreamer's recent activities (called "day residue").

For psychoanalytic purposes, though, the most interesting aspect of dreams is their *latent content*: the unconscious ideas, fantasies, and impulses that may appear in disguised form. The process through which clients transform unacceptable unconscious material into acceptable manifest content is called *dream work* (Freud, 1900), so most manifest dream content is viewed as symbolic of something else—the specifics of which differ among people and among dreams. Thus, after hearing about Lena's dream, Dr. Kim might look for latent content in the free associations she makes to, say, trees and water, and running. In spite of the popular belief that certain dream symbols (e.g., a snake) always mean the same thing (e.g., a penis), Freud believed dreams must be interpreted more flexibly because each client's life experiences are different, as are the ways in which their unconscious minds record them. Nevertheless, Freud himself occasionally attributed specific meanings to specific symbols in his patients' dreams (Freud, 1900).

A typical approach to exploring a dream's unconscious meaning is to

ask the client to free associate to its manifest content. Dreams are not explored in isolation, though. Psychoanalysts typically consider material coming from a series of dreams in an effort to find patterns of latent content across dreams. In other words, dreams provide ideas for further probing more often than they provide final answers.

Analysis of the Transference. When a miniature version of the causes of the client's problems appears in the therapeutic relationship, it is called the **transference neurosis** and becomes the central focus of analytic work. This reproduction of early unconscious conflicts, and the psychological and physical reactions associated with them, allows the analyst to deal with important problems from the past as they occur in the present. Analysts must be careful as they try to decode the meaning of their clients' feelings toward them. If an analyst responded "normally" to a client's loving or hostile comments, the client would not learn much about what those comments reflect. Instead, the therapist's goal is to understand the meaning of the client's feelings and help the client understand that meaning, too. If this can be done, the psychological and biological aspects of the transference neurosis will be resolved and, with it, the client's main unconscious conflicts.

Transference neurosis
The reenactment of the causes of the client's problems within the therapy relationship.

Analysis of Resistance. When clients behave in ways that interfere with the analytic process, it is considered a sign of *resistance* against achieving insight. In Lena's case, Dr. Kim tries to overcome her resistance by pointing out when it appears in the form of obstructed free associations, avoidance of —or sudden changes in—certain topics of discussion, difficulty in reporting dreams, missing or being late for appointments, failing to pay her bill on time, and the like (Fine, 1971; Portuges & Hollander, 2011). Even her desire to address her most troubling symptoms rather than possible intrapsychic conflicts, and her concerns about the lack of progress in treatment, might be seen as efforts to divert attention from the unconscious causes of her problems.

Combining Psychoanalytic Techniques. Like all psychoanalysts, Lena's therapist wants her to gain insight into her unconscious conflicts, but doesn't want to overwhelm her with potentially frightening material before she is ready to handle it. Through questions and comments about her behavior, free associations, dreams, and the like, the analyst guides the process of self-exploration. So when Lena shows resistance to seeing the potential meaning of some event, her therapist not only points out the resistance but also proposes an interpretation of what is going on.

As we suggested earlier, the interpretive process is a tentative and ongoing one that offers constant encouragement to consider alternative views, to reject obvious explanations, and to search for deeper meanings. As interpretations help clients understand and work through the transference, the therapeutic relationship is expected to change. Clients not only see how defenses and unconscious conflicts caused problems, but they learn to deal differently with the world, beginning with the therapist. They also learn that forces from their past no longer need to dictate their behavior in the present.

Ideally, this emotional understanding will liberate the client to deal with life in a more realistic and satisfying manner than before.

This is what happened in Lena's case. She explored her feelings about her childhood, especially her ambivalent feelings about her father. She had admired her father and longed to win his affection, but she now realizes that he was interested only in himself and she can now experience rage at his selfishness and cruelty toward her and her mother. Lena also became aware that her father's behavior toward her in childhood had affected her self-concept and self-esteem. She had worked to convince herself that she was attractive and special, especially during her "wild years" in high school and college, when she made a considerable effort to attract men. She was typically successful, though only with men who did not really interest her and who were not interested in her as a person.

With Dr. Kim's help, Lena considered the possibility that her relationship patterns with men not only provided a way to prove her father wrong (that she is not ugly), but also reflected a symbolic effort to gain his affection and loyalty. She may have held an unconscious belief that had she been more attractive and appealing, he might not have abandoned the family. Indeed, fear of abandonment and a desire for interpersonal power seemed to pervade her relationships with men; in every case, it was she who ended the relationship, thus avoiding the possibility of being deserted.

In one particularly significant session, as Lena was exploring her feelings about her marriage, she said she sometimes imagined leaving the relationship or at least having an affair. It was then that she recalled more about what happened on the evening of her first panic attack. She realized that she had been tempted to have a one-night stand with the "greasy" but good-looking man who had approached her at the continuing education

weekend. Because she was married, she was ashamed and overwhelmed by this impulse and instead of acting on it, went to her hotel room, where the panic attack occurred. Several things seemed to connect in this session—sexual impulses, fears of loss, strivings for autonomy and self-esteem, and the feeling of panic.

As her psychoanalysis continued, Lena and Dr. Kim began to sense a better understanding of the complex emotional currents that had defined her relationships. She gained insight into her unconscious concern that her husband's disengagement and his time spent with his friends foreshadowed his abandonment of their marriage, and she became less worried about his leaving. She recognized that her husband—though struggling with his own problems—was fundamentally different from her "dashing" but uncommitted father. Her panic attacks ceased, and her relationship with her elderly mother improved when, despite the mother's failing health, she was able to have a candid conversation about her father (who had died in a psychiatric hospital when Lena was in her early twenties; see Chapter 14 for more on his story).

Ironically, as things improved, Lena began to worry that her therapist was now less interested in working with her. After she missed an appointment due to what she said was a schedule conflict, Dr. Kim asked her to consider if her feelings about therapy had changed. She admitted that she had been thinking that perhaps she had gone as far as she could go in treatment. Should they terminate? Dr. Kim advised against it because he felt that they were still working through some important material, and he recognized that her talk of termination might be a form of resistance or perhaps an effort to end yet another relationship before she could be abandoned.

Lena missed the next session. When she showed up a few days later, she

was cheerful and dressed far more provocatively than usual, but she reported having had another panic attack. When Dr. Kim commented on her demeanor and her clothing, Lena angrily complained that he didn't appreciate her attempts to cheer herself up or to make their interaction more pleasant. She accused him of secretly wanting to terminate the relationship because he was bored with her. This session and others that followed were especially productive because they provided opportunities to analyze the transference material and Lena's resistance (suggesting termination, missing appointments). Dr. Kim suggested that Lena's feeling that her therapist no longer cared about her was a reflection of how she had felt about her husband and her father. Her attempts to prevent being abandoned by being more cheerful, attractive, and even seductive (but emotionally inauthentic), and then feeling angry, were also reflections of a long-established relationship pattern.

Lena came to appreciate the repetitive unconscious conflicts that affected her most intimate relationships. She was eventually able to more clearly differentiate the therapist from her father, as she had begun to do with her husband. Her self-esteem improved, and her depression eased, but due to the various stressors at home and at work, it did not entirely disappear. She was glad that she could now at least recognize the feelings and behavior patterns that went with her old relationship scripts and this insight allowed her to try out other ways of relating to her family and colleagues. In short, by making unconscious conflicts conscious and then working through them in psychoanalysis, she was no longer compelled to repeat them. Her insights allowed her to gain greater control over her impulses and fears.

Because of space limitations, our account of classical psychoanalysis has been brief, and forced us to omit many details and simplify others. If you

are interested in learning more about psychoanalysis, we encourage you to consult other sources (e.g., Borden, 2009; Diamond & Christian, 2011; Eagle, 2011; Freud, 1949; Elzer & Gerlach, 2013; Gabbard, 2010; Norcross, Vandenbos, & Freedheim, 2011; McWilliams, 2004; Summers & Barber, 2009; Thomä & Kächele, 1987, 1992; Willock, 2007; Wolitzky, 2011), or take a course focused more specifically on psychotherapy methods.

Thinking Scientifically Is Freud Dead?

Among clinical psychologists, few names arouse as many strong emotions, both positive and negative, as that of Sigmund Freud. Even today, a debate rages over whether Freud's vast body of work remains relevant more than eight decades after his death. Some scholars (e.g., Solms, 2004; Westen, 1998) contend that Freudian theory has, with some exceptions, held up well in light of scientific evidence, whereas others (e.g., Kihlstrom, 2003; Paris, 2017) disagree. Evaluating the scientific support for Freud's theories is no easy task. That's largely because Freud's model of personality is sprawling and complex.

What am I being asked to believe or accept?

Freud's model rests on several key assumptions (Loevinger, 1987). Among the most central are that (a) unconscious drives, especially sex and aggression, are the primary influences on our personalities; (b) our early sexual development profoundly shapes our adult personalities; and (c) dreams and neurotic symptoms are *symbols*. By symbols, Freud meant that these psychological phenomena disguise a deeper meaning; for example, a patient's specific phobia of dogs may

actually reflect an unconscious fear of his father, whose beard was fuzzy like a dog's. In addition, Freud contended that his method of psychoanalysis, which aims to bring unconscious conflicts into awareness, is the only sure means of healing psychological ills.

What kind of evidence is available to support the claim?

One can find indirect evidence to support certain key elements of psychoanalytic theory. Freud was undoubtedly correct that we are often unconscious of the true causes of our behavior (Overskeid, 2007). One striking example derives from patients with severe amnesia (memory loss) arising from brain damage. Despite their severe memory deficits, these patients can acquire new skills, such as learning to trace shapes using a mirror, but when asked where and how they obtained these skills, they are clueless (Kihlstrom, 1999). Even among people with undamaged brains, there is evidence that stimuli presented below the threshold of awareness, or so-called "subliminal stimuli," such as an angry face flashed too quickly for us consciously to detect it, can affect our short-term moods (Wilson & Bar-Anan, 2008). Freud was also right that early life experiences can influence our development. For example, even when controlling for genetic risk, childhood physical abuse forecasts the likelihood of later behavioral problems (Jaffee et al., 2004).

Are there alternative ways to interpret the evidence, including those that my biases and preconceptions might have kept me from seeing?

At first blush, these findings might seem to offer encouraging support for Freud's model. But closer inspection reveals a different picture. Freud viewed the unconscious mind as a seething cauldron of sexual and aggressive drives that affects our conscious behaviors in powerful ways. In contrast, contemporary research in cognitive psychology suggests that the unconscious consists of numerous mental processes, such as habit learning, pattern recognition, and emotional reactions, that occur rapidly and without awareness. This conceptualization of the unconscious bears minimal resemblance to that described by Freud (Kihlstrom, 1999). Moreover, although there is little doubt that childhood experiences can shape later development, there is no good evidence that the kinds of early experiences that Freud hypothesized to be critical, such as the quality of breastfeeding and toilet-training, play any major role in personality formation (Fisher & Greenberg, 1996). In addition, although psychodynamic therapies appear to be effective for certain psychological problems, they do not seem as effective as other methods, such as cognitive behavior therapy (Anestis, Anestis, & Lilienfeld, 2011; Lorentzen, Raud, & Fjeldstad, 2013). Furthermore, because most modern psychodynamic therapies incorporate cognitive behavioral techniques, such as exposing patients to their long-avoided anxieties, much of their effectiveness may stem from their overlap with these better-supported methods (Paris, 2017). When considering this evidence, we must also bear in mind that Freud regarded psychoanalysis as the *only* dependable means of alleviating mental suffering. Yet the data are clear that other forms of therapy can be effective even though they do not explicitly address childhood experiences or presumed unconscious conflicts

(Wachtel, 1997).

What additional evidence would help to evaluate the alternatives?
Even if future evidence were to show psychoanalytic therapy to be significantly more effective than other modes of therapy for certain problems, it would not verify the other core assumptions of Freud's theory, such as the claim that dreams and neurotic symptoms are symbolic representations of unconscious conflicts. Another major problem with appraising Freud's theory is that large portions of it, such as the assertion that all young boys are sexually attracted to their mothers, are exceedingly difficult to test scientifically (Meehl, 1978). Were researchers to one day find a satisfactory means of testing such hypotheses, psychoanalytic theory might receive stronger scientific support. At present, however, this scenario seems unlikely.

What conclusions are most reasonable given the kind of evidence available?
There is little question that Freud was a brilliant thinker who successfully anticipated several discoveries in cognitive, personality, and clinical psychology. He correctly observed that we are often unaware of why we do things yet readily concoct plausible after-the-fact explanations for our behavior. He was also right that childhood experiences can influence our personalities, and he was among the first scholars to recognize that psychotherapy can alleviate neurotic symptoms. Still, most of Freud's insights have since been absorbed into other, better-supported, theories of personality and psychopathology, so although we should appreciate Freud's historical

contributions to clinical psychology, it is less clear that his model offers much to the contemporary science of mental illness and its treatment.

In Review Psychoanalysis

Theoretical assumptions	Behavior and behavior problems are caused largely by unconscious conflicts among id, ego, and superego.
Therapist's role	Maintain a neutral ("analytic incognito") stance in order to help clients explore their unconscious conflicts, impulses, and fantasies.
Goals of therapy	Gain insight into, and fully understand (work through), the role played by defense mechanisms and other unconscious material in maintaining maladaptive patterns of thought and action, thus eliminating the need to continue those patterns.
Main treatment techniques	Provide clients with emotional support while offering interpretations of the unconscious meaning of what they say and do, focusing specifically on: 1. What clients say and do while free-associating 2. The transference (the "replay" of clients' past relationship problems within the therapeutic relationship) 3. Resistance to treatment 4. Dreams 5. Mistakes, slips of the tongue, and other everyday behaviors.

Test Yourself

1. When Freud found that not all his clients could be hypnotized, he substituted a method known as __________ to help them uncover unconscious material.

2. Clients' feelings of anger toward or affection for their psychoanalyst are seen as examples of _____________.

3. Projection, reaction formation, and displacement are all examples of what Freud called ______________.

You can find the answers in the Answer Key at the end of the book.

Psychodynamic Psychotherapy

Section Preview In this section you will see that after Freud proposed his psychoanalytic theories and therapy methods, many other theorists have offered alternative formulations and treatments. These alternatives differ from classical psychoanalysis in varying degrees but they all share three main characteristics: they (a) deemphasize or reject the role of sexual and aggressive id impulses as the main drivers of personality development and focus on the ego and its adaptive functions; (b) emphasize the nature and role of our closest early relationships; and (c) highlight the healing aspects of the therapeutic relationship. In this section, we describe the treatments developed by these psychodynamically oriented clinicians. As in the case of psychoanalysis, we hope you will read about psychodynamic theories and treatment methods with an open mind, while also paying close attention to the section on the "Current Status of Psychodynamic Psychotherapy," where we summarize what scientific research evidence says about their effectiveness.

The criticisms of classical psychoanalysis described in the last section are not new. Even some of Freud's earliest colleagues, though attracted to the basics of his theory and his therapy methods, saw shortcomings that led them to propose their own alternatives. Since Freud's death in 1939, many other psychiatrists and psychologists have developed still other variations on his ideas.

The early variants are often called *psychoanalytically oriented* psychotherapies, mainly because the individuals who developed them were

so closely associated with Freud as to be known as “*neo-Freudians*.” In fact, though, almost all of the theories and methods that were stimulated by Freud’s work are more accurately called **psychodynamic psychotherapies** because they share to some degree three important characteristics: First, instead of focusing on sexual and aggressive (id) instincts in the development of behavior and behavior disorder, these therapies emphasize more positive aspects of personality, especially the role of the ego in motivating psychological growth, and not just resolving intrapsychic conflicts. Second, while emphasizing the importance of early relationships with the mother or other caregivers, the theorists who developed these treatments did not see those relationships as revolving mainly around sexuality. As a result, their treatments focused more on the nature, strength, and consequences of the attachment or bonding that occurs in early relationships with caregivers. Third, these alternative treatment approaches tend to see the therapeutic relationship not just as an arena for analyzing transference but as having healing properties in and of itself. Let’s consider some of the most prominent of the psychodynamic psychotherapies.

Psychodynamically oriented psychotherapy
Variations on psychoanalytic treatment that departed significantly from the principles and methods of Freud’s original theories.

Adler's Individual Psychology

Viennese physician Alfred Adler was an early member of Freud's inner circle, but left it when he became the first to develop a treatment approach that differed from orthodox psychoanalysis. This *Adlerian* (also called "*individual*") therapy approach deemphasized Freud's theory of instincts, infantile sexuality, and the role of the unconscious in determining behavior. Adler believed that the power behind the development of personality and disorder comes not from id impulses but from an innate desire to overcome infantile feelings of helplessness and to gain some control over the environment. Adler (1927/1963) referred to this process as *striving for superiority*, by which he meant a drive for fulfillment as a person, not just a desire to do better than others. According to Adler, this striving is motivated by feelings of helplessness (inferiority) experienced in childhood. When such feelings are too intense, which can result when young children are either overprotected or neglected, a normal striving for superiority can become all-powerful and motivate desperate and unhealthy efforts to enhance self-esteem.

Alfred Adler (1870–1937)
Adler emphasized the importance of what philosophers have called the *fundamental anthropological condition*, namely being born helpless and dependent (e.g., Laplanche, 1991). This condition, said Adler, has innumerable consequences for our psychological development.

(Source: Hulton Archive/Stringer/Getty Images.)

Adler's treatment methods focused on exploring and altering misconceptions (or maladaptive lifestyles, as he called them). So, suppose Rachel Jackson reports that she vomits before leaving for school most mornings. A strict Freudian might interpret this behavior as an unconscious defense mechanism, but an Adlerian would probably see it as reflecting anxiety brought about by a misconception such as "I must be accepted by all of my new friends." Where Freudians offer interpretations designed to promote insight into past causes of current problems, Adlerians interpret behavior to promote insight into the client's current lifestyle. Adlerian therapists use modeling, homework assignments, and other techniques to help clients become aware of their lifestyle and to prompt them to change.

Another key difference between Adlerian therapy and psychoanalysis is that Adlerians focus more on the social and relational aspects of psychopathology and less on its intrapsychic ones. Adler’s flexible treatment methods and his emphasis on relational contexts were early examples of some of the important changes in psychoanalytic theory that were to come. Aspects of his approach can also be seen in the humanistic therapies described later in this chapter and in the cognitive behavioral treatments described in the next one (Borden, 2009).

Jung’s Analytical Psychology

Swiss psychiatrist Carl Jung had been another of Freud’s pupils and close colleagues, though they eventually parted ways over theoretical differences. Jung’s variation on psychoanalysis, called *analytical psychology*, differed from Freud’s in several ways. For one thing Jung stressed the importance of the ego over the id and superego. He viewed the unconscious not so much as a cauldron of conflicts threatening to boil over with anxiety, but as a source of innate drives for creativity and growth. He saw people as capable of using their experience to resolve inner conflicts, and to find ways of blending basic impulses with real-world demands. So in contrast to classical psychoanalysts, Jungian therapists focus less on the unconscious meaning of symptoms, and more on how clients *create* meaning as they construct their life stories (Stekel, 2013). Jung also emphasized the importance of what he called the *collective unconscious*, which he believed consists of culturally universal symbols. For Jung, this region of the human mind accounts for the existence of universal myths and such mythic figures as the hero, the wise person, and the black sheep that appear across cultures. Jung’s approach, like Adler’s, would become central to later psychodynamic approaches and especially to humanistic approaches (Sedgwick, 2013).

Ego Psychology

Taking their cue from Adler and Jung, a group of psychodynamically oriented therapists known as *ego analysts* argued that Freud's preoccupation with sexual and aggressive instincts as the basis for behavior and behavior disorder was too narrow. Behavior, they said, is determined to a large extent by the ego, which can function not just to combat id impulses or to referee conflicts between id and superego but also to promote learning and creativity. These ideas led analysts such as Heinz Hartmann (1958), David Rapaport (1951), Erik Erikson (1946), and Freud's daughter, Anna (1946), to use psychoanalytic techniques to explore patients' adaptive ego functions.

Ego-analytic techniques differ from classical analytic techniques in that therapists focus less on working through early childhood experiences and more on working through current problems. Therapists assess and attempt to bolster the client's *ego strengths,* which include reality testing, impulse control, judgment, and the use of more "mature" defense mechanisms such as sublimation and humor, rather than "immature" ones, such as denial. In ego psychology, the therapeutic relationship remains important, but less as a target for analysis of transference and more as a source of support and trust.

Object Relations Therapy

Another prominent variation on psychoanalysis has emerged from *object relations theory*, a viewpoint associated largely with a group of British analysts including W. R. D. Fairbairn (1952), Donald Winnicott (1965), Melanie Klein (1975), and Margaret Mahler (Mahler, Pine, & Bergman, 1975), as well as Otto Kernberg (1976) and Heinz Kohut (1977, 1983). Whereas ego psychology expanded the role of the ego, object relations theory expanded the role of interpersonal relationships in psychodynamic thought.

Object relations therapists believe that most of the problems that bring clients to treatment stem from the nature of their earliest social relationships, especially their pattern of emotional attachment to their mothers or other caregivers (Ainsworth et al., 1978; Blatt & Lerner, 1983; Bowlby, 1973; Eagle, 1984). (The term *object* usually refers to a person who has emotional significance for the client.) These early relationships act as prototypes for later ones, they say, so disruptions in them can have profound negative consequences in adulthood. Therapists who adopt an object relations perspective take a much more active role in treatment than classical analysts do—particularly by directing the client's attention to evidence of certain conflicts, rather than waiting for free association or transference analysis to reveal them. Object relations therapists also work to develop nurturing relationships with their clients, providing a "second chance" for them to receive the support that might have been lacking in infancy and to counteract the consequences of maladaptive early attachment patterns (Kahn & Rachman, 2000; Wallerstein, 2002). For example, object relations therapists take pains to show that they will not abandon their clients, as might have

happened to these people in the past. This effort can be especially beneficial for clients like Lena Jackson.

This emphasis on ego support, acceptance, and the psychological "holding" of damaged selves has made object relations therapies among the most popular psychodynamically oriented treatments today, largely because they allow a friendlier, more natural therapeutic relationship, which many therapists prefer over the more traditional Freudian neutrality.

Relational Psychodynamic Psychotherapy

Like object relations theorists, *relational psychodynamic* theorists stress the idea that a client's early relationships with caregivers serve as templates for later ones. However, they also point out that these early relationships have an objective dimension (established by actual characteristics and events) and a subjective one (the way the relationships are perceived and remembered). It is the subjective aspect of early relationships that plays an especially important role in relational psychodynamic theory and practice.

So, in contrast to Freud's analysis of sexual and aggressive impulses and the *intra*personal (internal, intrapsychic) relations among a client's id, ego, and superego, relational theorists seek to understand the client's *inter*personal relationships. American psychiatrist Herbert "Harry" Stack Sullivan is generally seen as the originator of this interpersonal perspective and the relational psychodynamic therapy methods flowing from it (Sullivan, 1953). Sullivan believed that therapists should use their observations of the client's current and past interpersonal relationships to clarify for them how their typical cognitions and behaviors create what he called *problems in living*. His approach served as the basis for the interpersonal psychotherapy methods we describe later in this chapter. Sullivan and the relational therapists who came after him cautioned against assuming that the therapist's view of the therapeutic relationship is objectively correct. They pointed out that the client and the therapist each have their own subjective viewpoints and neither can be objectively validated.

Harry Stack Sullivan (1892–1949)

Sullivan's interpersonal theory of psychiatry led him to base treatment on helping clients to identify the specific behaviors that create their problems in living, the interpersonal situations in which these behaviors occur, and the impact of the anxiety associated with them. He then encouraged clients to address their problems by adopting more adaptive behaviors (Ford & Urban, 1963). These methods reflect one of his most notable assertions: "It is easier to act yourself into a new way of feeling than to feel yourself into a new way of acting."

(Source: Granger Historical Picture Archive/Alamy Stock Photo.)

The relational psychodynamic approach has achieved considerable popularity in the United States (DeYoung, 2003; Wolitzky, 2011), partly because of its compatibility with the broader intellectual trend variously called *intersubjectivism*, *constructivism*, or *postmodernism* (Neimeyer & Bridges, 2003). Central to this trend is the idea that no objective authority can judge whether one view of reality is "correct," but that jointly constructed views are nevertheless meaningful. Accordingly, relational psychodynamic therapists view the shared conceptual and interpersonal understanding that develops between client and therapist as a psychological system worthy of analysis in its own right (Stolorow, 1993). Relational psychodynamic therapies are sometimes called "two-person theories" (Gabbard, 2010) because they focus on how clients and therapists co-create meaning during the treatment process.

Short-Term Psychodynamic Psychotherapy

During the 1930s and 1940s, Hungarian-born psychiatrist Franz Alexander and his colleagues at the Chicago Psychoanalytic Institute questioned the belief that psychoanalytic treatment must be an intense, years-long process in all cases (Alexander & French, 1946). They said that not all clients need to be treated on the traditional 5 day per week schedule. In fact, they thought that, in some cases, daily sessions create too much dependence on the analyst or become so routine that the client pays too little attention to them. So, although their clients might be seen every day early in treatment, later on, sessions could take place less often, usually once a week (Alfonso & Olarte, 2011). They distinguished, too, between clients who need lengthy psychoanalysis to fully explore and work through resistance, insights, and transference, and others—especially those with relatively mild or especially severe problems—who only need, or might only be able to benefit from, shorter treatment programs aimed mainly at providing emotional support (Alexander & French, 1946).

Intensive short-term dynamic psychotherapy (ISTDP) is one of the most notable examples of this kind of time-limited approach. Developed by Iranian psychoanalyst Habib Davanloo (1994), ISTDP emphasizes pragmatic goals that are achievable in relatively few sessions, typically no more than 20. Like other psychodynamically oriented clinicians, short-term dynamic therapists help clients to achieve and work through insights about early relationships, but they do so by focusing on a current crisis or problem rather than on the distant past. They try to form a working therapeutic alliance as quickly as possible and then encourage clients to adopt coping strategies to deal with

specific problems within specific domains, such as anxiety management skills or plans for handling a difficult relationship at work. Because the pace of therapy is accelerated, these therapists are much more active than other psychodynamic therapists. They encourage clients to focus immediately on the specifics of their problems, challenge them to recognize and abandon defenses that have been perpetuating those problems and, if necessary, create a "head-on collision" in which they point out that the client's resistance to self-examination will make significant improvement impossible. In the face of continued, particularly stubborn resistance, the therapist might say something like this: "Isn't there an element of self-defeat and self-sabotage? Why do you put a goal for yourself, to come here of your own volition so that together we can get to the core of your problem, but at the same time you want to make it a failure, which obviously means perpetuating your own suffering? (Davanloo, 1999. pp. 267-268). There are several models for short-term dynamic therapy, some of which include manuals for treating specific disorders (Binder & Betan, 2013; Levison & Strupp, 1999).

The Current Status of Psychodynamic Psychotherapy

In comparison to classical psychoanalysis, which is now practiced by only a small minority of clinicians, psychodynamically oriented therapies are far more popular. Indeed, the psychodynamic approach is the second most common one, after the cognitive/cognitive behavioral approach, among faculty members at accredited graduate and professional schools in clinical psychology (Norcross & Sayette, 2018). Psychodynamically oriented research publications are on the rise, too, although many critics argue —correctly, we think—that the case studies that still dominate the psychodynamic psychotherapy research literature lack scientific rigor (Kramer, 2009). As described in Chapter 7, large-scale reviews and meta-analyses have found that some forms of psychodynamic psychotherapy yield results that are comparable to those of therapies identified as empirically supported (e.g., Fonagy, 2015; Gerber et al., 2011; Shedler, 2010), but these conclusions have been challenged (Anestis et al., 2011). Critics point out that the greatest benefits are associated mainly with the short-term interpersonal approaches that we describe in the next section.

It also appears that most psychodynamically oriented clinicians are becoming less ideological in practice. Surveys suggest that, though these therapists clearly favor a psychodynamic framework, they are also inclined to endorse features from cognitive behavioral and other therapy approaches (Alfonso & Olarte, 2011). So, despite the tendency of some critics to dismiss all psychodynamic theory because certain aspects of Freud’s theory have been discredited, the psychodynamic approach continues to evolve, and it remains a significant force in clinical psychology.

In Review Psychodynamic Psychotherapy

Title	Theorists	Emphasis
Individual psychology	Alfred Adler	Striving to overcome feelings of inferiority; importance of social motives and social behavior.
Analytical psychology	Carl Jung	Humans are born not just with sexual and aggressive drives but also drives for creativity, growth-oriented resolution of conflicts, and the productive blending of basic impulses with real-world demands.
Ego psychology	Anna Freud, Erik Erikson, Heinz Hartmann, David Rapaport	Focus on current problems; bolstering adaptive ego functioning and establishment of firm identity and intimacy.
Object relations therapy	Melanie Klein, Otto Kernberg, Donald Winnicott, W. R. D. Fairbairn, Margaret Mahler	Modifying mental representations of interpersonal relationships that stem from early attachments; using the nurturing therapeutic relationship to support change.
Relational psychodynamic and postmodern psychotherapy	Harry Stack Sullivan, Robert Stolorow	The interpersonal rather than intrapersonal contexts in which disorders appear. Importance of relationships with

		caretakers and exploration of the “intersubjective space” created jointly by client and therapist.
Short-term psychodynamic psychotherapy	Franz Alexander, Habib Davanloo	Focus on a current crisis or problem; quickly form a therapeutic alliance and encourage clients to adopt coping strategies to deal with specific problems within specific domains.

Test Yourself

1. Psychotherapists who developed treatments based on Freud’s classical methods are known as ___________therapists.

2. True or false? Revised versions of Freud’s psychoanalysis did not appear until after his death in 1939.

3. The nature of the attachment that develops between infants and their earliest caregivers is emphasized most by ___________therapies.

You can find the answers in the Answer Key at the end of the book.

Interpersonal Psychotherapy

Section Preview In this section, we describe Interpersonal Psychotherapy (IPT), a set of treatment methods focused on the links between current or recent life events, difficulties in relationships, and symptoms of psychological disorder. You will see that IPT shares some characteristics with various forms of short-term psychodynamic therapies, including its strong emphasis on interpersonal factors, but that IPT is a more targeted, time-limited, and present-focused approach and that, compared to psychodynamically oriented therapies, IPT has received stronger empirical support for its effectiveness in treating certain kinds of psychological problems.

The history of **interpersonal psychotherapy (IPT)** is rich and interesting and reflects the influence of a number of therapeutic traditions. Originally developed in the 1970s by Gerald Klerman and Myrna Weissman, IPT was first used as a psychotherapy treatment against which to compare the effects of antidepressant drug treatment for women with depressive disorders (see Bleiberg & Markowitz, 2014; Klerman et al., 1974). IPT was based on research showing that depression was related to various stressful life events, such as the death of a family member, divorce, or other major life transitions (Weissman, 2019).

Interpersonal psychotherapy

A time-limited treatment that focuses on resolving the interpersonal problems that underlie psychological problems such as depression.

Dr. Myrna Weissman is one of the founders of Interpersonal Psychotherapy, a treatment approach that aims to relieve depressive symptoms by identifying and solving a central interpersonal problem.

(Source: Supplied with permission of Dr. Myrna Weissman.)

IPT contains elements from Harry Stack Sullivan's interpersonal theory that we described earlier, as well as from John Bowlby's attachment theory (Bowlby, 1969), which emphasizes infants' innate drive to form attachments with other people. Both theorists highlighted the close links existing between problems in relationships and forming secure attachments and the development of psychological problems. IPT assumes that those problems

can stem not only from early relationships with caregivers, but from relationships that occur throughout the life span, such as with a boss, a sibling, or a romantic partner.

IPT is normally conducted once a week for no more than about 4 months. In the first one-to-three sessions, the therapist explains that depression is an illness for which the client is not to blame, and that it is related to interpersonal events in the client’s life. To help the client understand the role of these events, the therapist takes an "interpersonal inventory" of the client’s typical relationship patterns, capacity for interpersonal intimacy, and current relationship problems. The guiding assumption is that depression is linked to one or more of four key interpersonal challenges: (a) the loss of a loved one; (b) ongoing conflicts with family members, friends, or coworkers; (c) major life changes (e.g., becoming a parent, divorcing, retirement) that result in a social role transition; or (d) not having enough significant interpersonal relationships.

In the next stage of treatment—about 12 sessions—the therapist encourages the client to work on resolving the most significant of these problematic interpersonal circumstances. This might take the form of helping the client to fully express both positive and negative feelings about the lost loved one, find a mutually acceptable solution to nagging conflicts, learn to say goodbye to a previous role in life and to embrace a new one (including an authentic evaluation of the gains and losses that accompany the changing roles), or develop strategies to be less socially isolated. Treatment sessions focus on discussions of the links between interpersonal problems and distressing symptoms, and can also involve role-playing that allows clients to practice new ways of interacting in a relationship and to carefully analyze past communication patterns. Throughout the process, the therapist acts as a

sort of coach and guide, providing support, offering congratulations for progress, and making suggestions when new ideas are needed. In many cases, especially when there are concerns over recurring depression, the client meets with the therapist on a monthly basis for some period of time after the formal part of treatment is over.

The Current Status of Interpersonal Psychotherapy

IPT has received strong research support for its effectiveness as a treatment of depression in a range of client populations, including adolescents and older adults. It is now included in many clinical practice guidelines as one of the best-established treatments for depression (e.g., the National Institute for Health and Care Excellence in the United Kingdom). In fact, a meta-analysis of 90 research studies conducted with more than 11,000 clients found that IPT had medium to large effects in reducing depression symptoms when compared to a range of control groups, and performed as well as other established treatments, including cognitive behavior therapy and antidepressant medications (Cuijpers et al., 2016). Evidence suggests that IPT is beneficial not only in the treatment of the acute (i.e., current, clinically significant) symptoms of depression, but also for keeping less severe depressive symptoms from becoming acute and for preventing the reappearance of depression following the end of a depressive episode. The success of IPT in treating depression has led researchers to begin evaluating IPT variants for other problems, including eating disorders, anxiety disorders, and substance use disorders, among others. While there is less research on the effects of IPT for these other problems, results so far are promising.

One of the more interesting adaptations of IPT has been to advance global mental health, including by training people who are not mental health professionals to offer IPT in community settings in low- and middle-income countries (Singla et al., 2017). In one study, after receiving 2 weeks of intensive training in the basics of IPT, local “non-specialist providers” conducted 16 sessions of group-based IPT with the residents of rural villages

in Uganda (Bolton et al., 2003). Following the intervention period, far fewer people in the villages where IPT was provided met the criteria for a major depression diagnosis compared to those people in villages where IPT was not provided (6.5% vs. 54.7%). While much remains to be learned about which client populations can benefit from IPT, and under what conditions, these initial findings are exciting because they hold promise for enhancing the reach of therapies to help people who typically do not receive mental health care.

In Review Interpersonal Psychotherapy

Basic assumptions	Psychological problems are closely related to difficulties in relationships and interpersonal losses and transitions.
Role of the therapist	Serves as a supportive guide who focuses the discussion on interpersonal issues and their links to psychological problems.
Main treatment methods	Identifying links between interpersonal problems and current symptoms. Analysis of communication patterns that may contribute to interpersonal difficulties. Exploring positive and negative aspects of key relationships and interpersonal role transitions. Practice relating to significant others in new ways, including through role-plays.

Test Yourself

1. Interpersonal therapy is based on the idea that a key factor maintaining depressive symptoms and other psychological problems is__________________.

2. Therapists and patients collaboratively select one of the following four interpersonal problem areas to focus on in therapy: ___________, ___________, ___________, ___________.

3. Interpersonal therapy is playing an increasingly important role in advancing global mental health given it can be administered by _________________.

You can find the answers in the Answer Key at the end of the book.

Humanistic Psychotherapy

Section Preview In this section, we describe humanistic approaches to psychotherapy, which emphasize conscious awareness rather than unconscious conflict. These approaches also stress the need for the therapist to understand the experiential worlds of their clients and to communicate that understanding as a way of creating a favorable climate for psychotherapy. The client–therapist relationship itself is seen as the primary curative factor in humanistic psychotherapies. As you will see in the section on “Current Status of Humanistic Psychotherapy,” these methods have come in for a fair share of criticism because they are not uniformly supported by empirical research on their effectiveness.

As described in Chapter 2, the humanistic approach to psychology arose partly as a reaction against both the psychoanalytic view of humans as driven by sexual and aggressive instincts and the behaviorist idea that they are mainly the products of learning based on reward and punishment. In accordance with humanist philosophy, clinical psychologists who adopt a humanistic approach see their clients as creative beings, capable of psychological growth, and who, if all goes well, consciously guide their behavior toward realization of their fullest potential as unique individuals. From this perspective, behavior disorders arise from disturbances in awareness or restrictions on existence that can be eliminated through various therapeutic experiences (Fischer, 1989; Greenberg, Elliott, & Lietaer, 1994; Joseph & Murphy, 2013).

Several themes unify the assumptions, goals, and techniques associated with these humanistic therapy experiences. First, humanistic therapists assume that their clients' lives can be understood only from the viewpoint of those clients. Second, humanistic therapists view human beings not as instinct-driven creatures but as naturally good people who are able to make choices about their lives and determine their own destinies. Third, in accordance with the *positive psychology* movement that is so prevalent today, humanistic therapists focus on amplifying clients' strengths rather than just addressing their problems. Indeed, some scholars have argued that positive psychology—the study and promotion of human flourishing—originated with the humanistic psychologists (Bohart & Greening, 2001). Fourth, these therapists see the therapeutic relationship as the primary vehicle by which treatment achieves its benefits. It must be a relationship that guarantees honest, emotionally open interpersonal experiences for both client and therapist. This principle implies that clients are regarded by their therapists as equals, as responsible individuals who are experts on their own experiences and who must ultimately be the ones to make decisions about their lives. Finally, many humanistic therapists emphasize the importance of experiencing and exploring emotions that are confusing or painful and stress the importance of clients focusing on their immediate, here-and-now experiences.

The most prominent examples of humanistic treatments are *person-centered psychotherapy* (Rogers, 1951), *Gestalt therapy* (Perls, 1969), and *existential therapy* (May, 1981; Frankl, 1967).

Person-Centered Therapy

American psychologist Carl Rogers' *person-centered psychotherapy* is by far the best known of the humanistic approaches. Originally trained in psychodynamic therapy methods in the late 1920s, Rogers eventually became uncomfortable with the idea of therapists as authority figures who used free association and other psychoanalytic methods to search for unconscious conflicts. He felt that there had to be a better way to do clinical work, and his alternative approach began to take shape when he discovered the therapy methods advocated by Otto Rank, an early colleague of Freud's who later developed his own therapy approach called Will Therapy. To Rank, the client "… is a moving cause, containing constructive forces within, which constitute a will to health. The therapist guides the individual to self-understanding, self-acceptance. It is the therapist *as a human being* who is the remedy, not his technical skill… . The spontaneity and uniqueness of therapy lived in the present carry the patient toward health" (Meador & Rogers, 1973, p. 121; italics added).

Carl Rogers (1902–1987)

Rogers' *person-centered psychotherapy* was originally called *client-centered therapy* but he later changed the name to emphasize that clients are first and foremost human beings.

(Source: Bettmann/Getty Images.)

Rogers believed that people have an innate motive or drive toward growth, which he called the *actualizing tendency:* "the directional trend which is evident in all organic and human life—the urge to expand, extend, develop, mature—the tendency to express and activate all the capacities of the organism" (Rogers, 1961, p. 351). Rogers saw all human behavior—from basic food-seeking to artistic creativity, from normal conversation to bizarre delusions—as a reflection of the individual's efforts at *self-actualization* in a uniquely perceived world. As Rogers began to incorporate these ideas about growth, non-authoritarianism, and the value of a good human relationship into his therapy sessions, he came to believe that "it is the client who knows what hurts, what directions to go, what problems are crucial, what experiences have been deeply buried" (Rogers, 1961, pp. 11–12). He also began to see therapy as an "if … then" proposition: *If* the correct circumstances are created by the therapist, *then* the client—driven by an innate potential for growth—will spontaneously improve.

The Self and Conditions of Worth. Rogers' person-centered theory of personality is based on the development of the self, the experiences that the person recognizes as "me." As children grow, he said, they come to understand their likes and dislikes, their abilities, emotional states, and the like, but these self-experiences do not develop in isolation. They appear in the context of the child's relationships with other people, especially parents.

In particular, children soon become aware that the things they say and do may be regarded by others in positive or negative ways.

In an ideal developmental environment, parents communicate acceptance (if not approval) of all of a child's behavior and experiences. Rogers called such communication *unconditional positive regard* and considered it as a critical requirement for psychological growth. To the degree that parents communicate unconditional positive regard, their child's behavior and experiences will be naturally incorporated into the *self-concept*. This means that the child comes to recognize these experiences as part of the self, and because others have valued them, the child values them, too.

It is far more likely, however, that parents, teachers, and peers communicate disapproval or rejection of some of the child's behaviors, feelings, and experiences, at least some of the time. When this happens, according to Rogers, they risk creating the impression that their acceptance and love, and the child's worth as a person, depends on the child's thinking, feeling, and acting in ways that they approve. These *conditions of worth*, Rogers said, are especially likely if the parents and others communicate disapproval of the *child* as a person rather than just disapproval of the child's behavior. For example, telling a child, "You're so stupid!" sends a different message than saying, "I love you, but it makes me angry when you do that."

Incongruence. Rogers said that children who develop under conditions of worth begin to adopt thoughts, feelings, and behaviors that reflect a socially approved, *ideal* self-concept rather than their genuine, *real* self-concept. In short, conditions of worth force people to distort their real feelings or experiences and the more they do so, the more separation, or *incongruence*, there is between the real self and the ideal self (see Figure 8.2). Rogers believed that incongruence lies at the root of many psychological

disorders. For example, the depression experienced by Rachel Jackson's father, James, might be due in part to the fact that although he really wanted to become an artist, he had to ignore this passion and bow to his parents' desire to see him in a more secure career as an accountant. In such cases, his growth as a person would have stopped as his thoughts and behaviors (majoring in accounting and professing satisfaction with this choice) became increasingly discrepant, or incongruent, with his real feelings. Rogers said that the distortions of a person's true feelings brought on by conditions of worth may not be entirely conscious, but that they are not as inaccessible as the psychoanalytic approach might suggest.

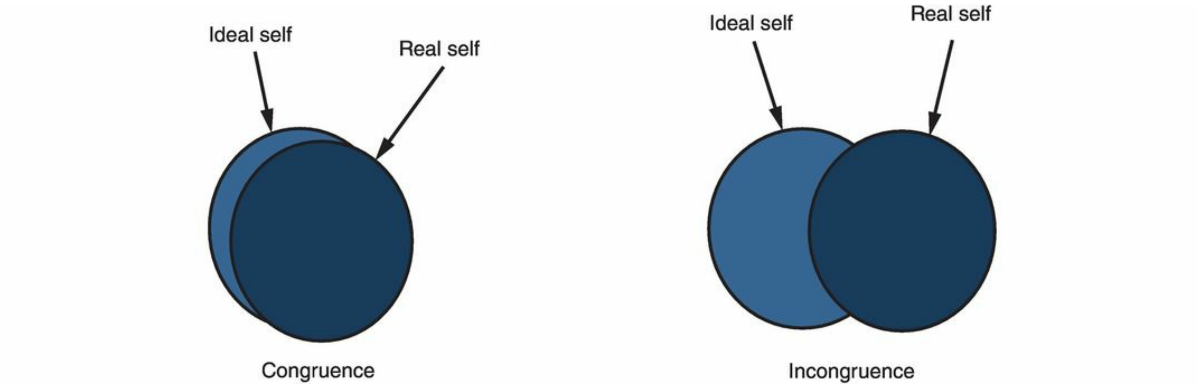


Figure 8.2 Congruence and Incongruence
According to Rogers, psychological problems result when conditions of worth cause people to severely distort their true thoughts and feelings, leading to incongruence, or separation, between the person's real and ideal self as well as blockage of self-actualization.

The Goals of Person-Centered Therapy

Because clients know what hurts and what they want to change, person-centered therapists do not set treatment goals; clients are free to select their own goals (Bohart & Watson, 2011). It is a key aim of **person-centered therapy**, though, to help clients become clearly aware of the true thoughts and feelings and other experiences that conditions of worth may have suppressed. The therapist promotes this awareness not by digging into clients' unconscious or exploring their distant pasts, but by providing an interpersonal relationship in which clients can feel accepted and free to be honest—with the therapist and with themselves—about who they really are and how they really think and feel. When clients can do that, said Rogers, incongruence will decrease and personal growth will resume, but growth-enhancing relationships can appear only if the therapist experiences and expresses three interrelated attitudes: unconditional positive regard, empathy, and congruence.

Person-centered therapy (client-centered therapy)
Treatment that focuses on creating a client–therapist relationship characterized by unconditional positive regard, empathy, and congruence that allows clients to become aware of their true thoughts and feelings and thus remove blockages to their personal growth.

Unconditional Positive Regard. The therapeutic attitude Rogers called **unconditional positive regard** makes it clear that the therapist cares about the client, accepts the client, and trusts the client's ability to change. The ideal form of unconditional positive regard is *nonpossessive caring*, in which genuine positive feelings are expressed in a way that makes clients feel valued but still free to be themselves, not obligated to try to please the therapist. The therapist's *willingness to listen* is an important aspect of unconditional positive regard. Patient, warm, and interested in what the client has to say, Rogerian therapists do not interrupt the client or change the subject or give other signs that they are giving the client less than their full attention.

Unconditional positive regard

In person-centered therapy, the therapist attitude that expresses caring for and acceptance of the client as a valued person.

The "unconditional" aspect of unconditional positive regard is manifested in the therapist's willingness to accept clients as they are without judging them. Rogers believed that the client's experience of being prized as a human being—no matter what feelings or impulses or behaviors the client expresses or describes—can be growth-enhancing for a person whose development has been hampered by conditions of worth and other evaluative pressures. Expressing unconditional positive regard does not require the therapist to *approve* of all the things a client says or does but merely to

accept them as part of a person whom the therapist cares about. This ideal is illustrated in the following interaction between Dr. Alison Goldberg (not her real name) and Rachel Jackson's father, James during a session of client-centered therapy:

JAMES: That was the semester my brother died and everything seemed to be going down the tubes. I knew how important it was to my parents that I qualify to continue my financial aid, so that I could finish my accounting degree, but I also knew that my grades would be lousy that year unless I did something. To make a long story short, I bought a term paper and cheated on almost every exam that semester.

DR. GOLDBERG: It was a really rough time for you.

Notice that the therapist focuses on the client's feelings in the situation, not on the ethics of his behavior. In other words, to express unconditional positive regard, the therapist must separate a client's worth *as a person* from the worth of the client's *behavior*.

The "positive" component of unconditional positive regard is reflected in the therapist's trust in the client's potential for growth and problem-solving. Rogers believed that if clients perceive that the therapist lacks this trust, they will not develop the confidence they need to make changes. So, like other humanistic therapists, Rogerians do not generally give advice, take responsibility for clients, or make decisions for them. Such restraint is sometimes difficult, especially when therapists feel that they know "what's best" for a client. However, trusting in the client's ability to make decisions includes allowing the client to make bad decisions or experience other problems. True, advice from the therapist might prevent such problems, but it may create others: the therapist would become a superior, the client would

become more dependent, and, most important, both client and therapist would have less faith in the client's ability to deal independently with problems.

Empathy. To understand a client's behavior and help the client understand it, too, the therapist must try to see the world as the client sees it. In Rogerian terms, this goal involves striving for accurate **empathy**, or *empathic understanding*. To illustrate, let's consider another excerpt from Dr. Goldberg's treatment of James, this one from their first session of client-centered therapy:

JAMES: My wife Lena was the one who wanted me to come. See, when I made the appointment, we'd just had another big fight over our daughter, Rachel. At that time, we were both really upset, near the end of our rope, so I agreed. [Pause] Not that it's much better now, but it has cooled down a little. You see, lately our life is a mess because our daughter is skipping school, flunking at least two of her classes, fights against everything we say. She, my wife I mean, thinks I'm too hard on our daughter but I don't think so. I think the kid needs to learn some self-discipline. I always have to be the bad guy, the one grounding her, taking the car away. Sure, I get angry at times, maybe say some things I shouldn't, and I drink more than I probably should, especially lately, but it's driving me crazy. I don't know how we're going to make it—it's like everybody is blaming everybody else for their unhappiness. I've been out of work for quite a while now, depending on my wife's income. I know some guys in my situation who just checked out in one way or another, if you know what I mean. I don't want to go down that road but…well, I can see how it happens. It just seems that life shouldn't be this hard. Shit, I feel like I'm just rambling. You must think I'm nuts.

After hearing an opening statement like this one, many therapists would adopt what Rogers called an *external frame of reference*. They would observe the client from the outside and apply their values or psychological theories to what the client says (see the left side of Table 8.2). As a client-centered therapist, however, Dr. Goldberg would adopt an *internal frame of reference* in an effort to develop empathy, an understanding of what it must be like to be this client (see the right side of Table 8.2).

Table 8.2 Therapist Thoughts That Reflect Internal and External Frames of Reference

External	**Internal**
He's being defensive, denying his problems.	When you made the appointment, you thought you needed help. Now that you're here, you aren't so sure.
The family is really dysfunctional, and he's a big part of the problem.	You're really concerned about your daughter.
He should learn more beneficial parenting techniques.	When you try to be a good parent, it backfires and you end up feeling blamed.
He may be alcoholic; I wonder if I should refer him to Alcoholics Anonymous.	From your perspective, alcohol adds to the problems at home, but it's not the main cause of the problems.
What is meant by this focus on marriage and family?	You're also concerned about how the stressors at home are affecting

	your marriage.
He’s unemployed. I wonder if he was fired because of his drinking.	In addition to the conflicts at home, you’re still struggling with the reality of unemployment, and it’s not easy.
He’s projecting his confusion and negative self-image onto me. I had better test him for depression and suicide potential.	You’re concerned that I might think you’re screwed up, a lost cause.

Empathy

In person-centered therapy, the therapist’s attempt to appreciate how the world looks from the client’s point of view.

To convey their empathic attitude toward clients, Rogerian therapists like Dr. Goldberg employ the active listening methods described in Chapter 4. Of particular value is *reflection,* which serves the dual purposes of communicating the therapist’s desire for emotional understanding and making clients more aware of the clients’ own feelings. Reflection is one of the most misunderstood aspects of person-centered therapy because the therapist appears to be stating the obvious or merely repeating what the client has said. In fact, though, reflection is far more than that. As described in Chapter 4, it involves distilling and “playing back” the client’s feelings. For example, suppose that in one session, James says, “This has really been a bad

day. I've felt like crying three or four times, and I'm not even sure why!" The therapist's response could be externally oriented, such as "Well, what exactly happened?" but Dr. Goldberg's more empathic comment was: "You really do feel so bad. The tears just well up inside. And it sounds like it is scary to not know why you feel this way."

At first glance, Dr. Goldberg may just seem to be parroting James' words, but look more closely. James never *said* he felt bad; she inferred it by taking his point of view. Similarly, James didn't say his sadness frightened him—it was Dr. Goldberg's ability to put herself in the client's shoes that led to this speculation. If her inferences are wrong, James can correct them, but right or wrong, she let him know that she wants to understand his experience rather than diagnose it.

Congruence. Rogers also believed that the more genuine the therapist is in relating to clients, the more helpful the therapist will be. The therapist's feelings and actions, he said, should display **congruence**, or consistency, with one another. "This means that I need to be aware of my own feelings … [and willing] to express, in my words and my behavior, the various feelings and attitudes which exist in me" (Rogers, 1961, p. 33). According to Rogers, when the therapist is congruent, a genuine human relationship occurs in therapy.

Congruence

In person-centered therapy, a consistency between the way therapists feel and the way they act toward clients.

Try this To get an idea of how congruence promotes trust, think of a time when a close friend might have told you something that you did not want to hear, perhaps that your clothes looked silly or that you were wrong about something. Once you know that a friend will say what he or she really feels even if it does not make you happy, it makes it easier to trust whatever else that friend might say. However, if you know that your friend can be incongruent, telling you what you want to hear instead of what he or she genuinely feels, your faith in that person's reactions ("You really look great.") is likely to be undermined.

Here is an example of how Dr. Goldberg's congruence was communicated to James in a later therapy session:

JAMES: I just feel so hopeless. Tell me what I'm doing wrong in my life.

DR. GOLDBERG: I guess when you are feeling this bad, it would be nice if someone could come along and tell you what is going wrong and how you can put everything right again. I wish I could do all that, but I can't. I don't think anyone else can either.

Notice Dr. Goldberg's reflection of James' feelings, plus her direct expression of a genuine wish to understand and solve his problems, and her admission that she is not capable of such a feat.

The Nature of Change in Person-Centered Therapy. Rogers believed that as clients experience empathy, unconditional positive regard, and congruence in a therapeutic relationship, they become more self-aware and self-accepting, more comfortable and less defensive in interpersonal relationships, less rigid in their thinking, more reliant on self-evaluation than on evaluations by others, and better able to function in a wide variety of roles (Rogers, 1951).

A Case Example of Person-Centered Therapy

Let's now follow James' progress in person-centered therapy. Over the course of the first few sessions, and simply by using active listening and reflection, Dr. Goldberg learns that James is 45 years old and grew up in a middle-sized southern city. As the eldest of six children in an African American family, he had been expected by his parents to be the first in family history to go to college, which he did, and though his accounting degree did not reflect his passion for art, it did provide a good career path and a steady income until he lost his job a little over a year ago.

It was then that he began to feel more and more depressed and that his drinking and obsession with neatness and order at home began to increase to problematic levels. He described himself as tired all the time, withdrawn from Lena and their three children, and less and less able to muster the energy to try finding a new job. With unemployment benefits long since exhausted, James worries about money and feels guilty about relying on his wife Lena's income. He says that she often expresses disapproval of him nonverbally, such as when she is paying their monthly bills. He says they argue frequently, not only about money and his inability to find work, but also about how to deal with the problems posed by their children, especially 17-year-old Rachel and 12-year-old Jamal.

Adding to James' feelings of inadequacy is the realization that, though not all of his siblings went to college, they are all more successful than he is. He feels that his parents are disappointed in him and his siblings secretly disrespect him, so he has had very little contact with any of them recently.

Despite Dr. Goldberg's empathic, accepting attitude during these early sessions, James seems uncomfortable, has difficulty maintaining eye contact, laughs nervously during the shortest periods of silence, and—not surprisingly, given his preference for neatness and organization—wonders aloud why there seems to be no structure to the treatment. He seems motivated to change, but he also has difficulty discussing his situation.

Case Formulation. As a person-centered therapist, Dr. Goldberg would not be inclined to make a formal DSM-5 diagnosis unless perhaps James' health insurance company requires one to approve reimbursement for her services. Attaching diagnostic labels reflects an external frame of reference that, as we mentioned earlier, is inconsistent with a person-centered approach. She would be far more interested in James' internal perspective, how he is experiencing his life, including, but not limited to, his symptoms. Her job is to enter James's experiential world, to try to see and feel things as he does, while still maintaining some professional objectivity (Sommers-Flanagan & Sommers-Flanagan, 2012). What she sees and feels so far is James' negative self-concept and how incongruent it is with his ideal self. For example, he appears to believe that to be a respectable man he should be the primary financial provider for his family. Because he is not fulfilling that role, he is not satisfying the conditions of worth that would merit approval from others and allow him to feel good about himself. He compares himself unfavorably to his siblings, and perceives them as disapproving of him, and his need for positive regard is not satisfied by his wife either. His guilt and depression and excessive drinking, then, are probably related to experiencing himself as a person who is not worthwhile.

The Role of the Therapist. Dr. Goldberg's primary responsibility as a person-centered therapist is to provide an emotionally safe atmosphere in

which James can explore these thoughts and feelings about the things that trouble him. She does so by continuing to be nondirective—she does not suggest topics, guide the conversation, or offer interpretations of James' thoughts or actions. Instead, she listens empathically, responds reflectively, and models genuineness in her own responses to James.

Her empathy is communicated through her ability to understand James' experiences, including emotions of which he is not fully aware. In one session, for example, he said that he "felt bad" when, after paying the bills, Lena said, "Holy crap, James, we're barely squeaking by!" Dr. Goldberg responded like this:

DR. GOLDBERG: When you heard that, you felt negative emotions right away. I'm trying to get a better handle on what that feeling was like for you.

JAMES: Well, like right away I feel myself tighten up. I know it's my fault. But I hate being reminded, you know. That doesn't help.

DR. GOLDBERG: So you feel yourself tighten or close up, then you get angry.

JAMES: Well, kinda. I don't really *say* I'm angry. I don't know, I just feel bad all over again. It's my fault.

DR. GOLDBERG: So when Lena mentions the finances, you feel criticized by her *and* by yourself. You think of yourself as a loser. Another part of you becomes self-protective, and that part tells you that the criticism doesn't help, it only makes things worse.

JAMES: Yeah, I guess I get all defensive. I *am* a loser.

DR. GOLDBERG: You don’t seem like a loser to me, James, and I think that if I felt criticized for being a loser on a regular basis, I’d want to protect myself too.

In this exchange, Dr. Goldberg worked to understand James’ feelings, including feelings that he may not yet fully accept as his own. Notice that she speculated that he felt anger, but his response suggested that this was not accurate; rather, he felt “like a loser.” She later restated James’ comment about “tightening up” as a self-protective impulse rather than anger. She did so because this might be a way of phrasing the experience that James can more easily “own.”

Dr. Goldberg also demonstrated congruence by reporting her own real feeling that James is not a loser. Congruence requires that the therapist be genuine and not try to maintain a facade of professionalism. However, this does *not* mean that therapists should just say whatever comes to mind, respond reflexively, or always “go with their gut.” Nor does it mean that therapists should routinely engage in confessional self-disclosure with their clients. Rather, congruence means that therapists should recognize in themselves their genuine and persistent feelings toward their clients and that they may express those feelings to the clients in an appropriate way (Rogers, 1967).

As person-centered therapy provides an atmosphere of acceptance, warmth, and genuineness, clients become more accepting of their own experiences. For example, James began to recognize the huge gap between what he thinks he should be and what he is. As he did so, he began to take a more internal perspective on his emotions and reactions—evaluating them from within his own experiential system rather than from the external

perspective provided by other people's evaluations. In other words, Dr. Goldberg helped James to expand his perspective rather than trying to change his behavior. Once he began to do so, he could start more fully experiencing emotions that were only vaguely experienced before.

James's increasing recognition and acceptance of his genuine self-experiences allows him to try out new behaviors in problematic situations. He now clearly recognizes, for example, that when Lena mentions money, his automatic tendency is to feel criticized, become emotionally defensive, angry, and to withdraw from the relationship. Because of his greater acceptance of himself and his situation, however, these feelings now have less power over him. And because he is less self-defensive, he can entertain the possibility that Lena is expressing concern for the family's welfare rather than accusing him of being inadequate. Further, because Dr. Goldberg has provided a model for responding to others with empathy, James can offer Lena his own more empathic response (e.g., "I know it's really frustrating and scary. I'm worried about the money too"). Even if James finds that Lena really *is* criticizing him, he may be better able to respond without withdrawing or counterattacking—saying, for example "I know you're upset, but I'm trying, and criticizing me doesn't help."

In short, the process of person-centered therapy is designed to develop a greater sense of self-trust. As clients get better at listening to their feelings, they become less likely to misread them, become less self-critical, and their sense of self-efficacy increases (Bohart & Watson, 2011; Sommers-Flanagan & Sommers-Flanagan, 2012).

Gestalt Therapy

Gestalt therapy is a kind of humanistic treatment approach developed by Frederick S. (Fritz) and Laura Perls. Like person-centered methods, Gestalt therapy aims at enhancing clients' self-awareness to free them to grow in their own consciously guided ways (Delisle, 2013). More specifically, the Gestalt therapist tries to reestablish clients' stalled growth processes by helping them become aware of feelings they have disowned but that are a genuine part of them, and recognize feelings and values they think are a genuine part of themselves but in fact were adopted through the influence of other people.

Gestalt therapy
An active form of humanistic treatment that seeks to create conditions in which clients can become more unified, more self-aware, and more self-accepting.

One of the key differences between person-centered therapy and Gestalt therapy is that Gestalt therapists are much more active and dramatic. Through a variety of therapeutic techniques, the client is encouraged to assimilate or "re-own" the genuine aspects of the self that have been rejected and to reject the "phony" features that do not really belong. Ideally, when clients assimilate and integrate all aspects of their personality (both the desirable and the undesirable), they start taking responsibility for themselves as they really

are instead of being attached to and defensive of a partially phony, internally conflicted self-image.

Focus on the Here and Now. Gestalt therapists believe that therapeutic progress is made by keeping clients in contact with their emotions and physical sensations as they occur in the immediate present—the here and now. Perls expressed this belief in a conceptual equation where *now* = *experience* = *awareness* = *reality* (Perls, 1970). He said that any attempt by the client to talk about the past or anticipate the future obstructs therapy goals because it is an escape from the reality of the now. So instead of reflecting (as a Rogerian might) the client's nostalgia for the past or worries about the future, a Gestalt therapist will point out the avoidance and insist that the client come back to the present moment.

Role-Playing. Using role-playing or part-taking, Gestalt therapists encourage clients to explore their inner conflicts and experience the symptoms, interpersonal games, and psychological defenses they have developed to keep those conflicts—and various other aspects of their genuine selves—out of awareness. For example, clients may be asked to "become" their resistance to change and say the things that their resistance would say. Doing so, said Perls, helps clients toward an experiential awareness of what their resistance is doing for them, and to them.

Gestalt therapists also turn role-playing into extended "conversations" between various parts of the client, including between the client's superego (what Perls called the "topdog") and the part that is suppressed by "shoulds" and "oughts" (the "underdog"). Using the *empty chair technique,* therapists encourage clients to "talk" to someone they imagine to be seated in a nearby chair. The other person might be a parent, child, spouse, or even an internalized aspect of the self. The client is asked to talk to the imagined

person and to express—perhaps for the first time—true feelings about him or her and about events or conflicts in which that person played a part. The client may even respond for the imagined person. Here is a short example of how the empty chair technique might play out if James Jackson had chosen to enter Gestalt therapy:

JAMES: My sister and I used to fight an awful lot when we were kids, but we seemed closer somehow then than we are now, especially since I lost my job.

THERAPIST: Can you put her in that chair and say this to your sister now?

JAMES: Okay. I feel so far away from you now, Rita. I want to have that feeling of being in a family again.

Clients may also be asked to clarify and release feelings toward significant people in their lives using the *unmailed letter technique*: They write—but do not send—a letter in which they express important but previously unspoken feelings. Role-played *reversals* are also used to enhance awareness of genuine feelings. For example, a client who conveys an image of cool self-sufficiency and denies feelings of tenderness toward others might be asked to play a warm, loving person. In the process, the client may get in touch with feelings that have been suppressed for many years.

Attention to Nonverbal Behavior. Gestalt therapists pay special attention to what clients do as they speak, especially when information from this nonverbal channel seems to contradict the client's words. Suppose, for example, that James Jackson clasps his hands as he says that he feels "nervous" today. As a person-centered therapist, Dr. Goldberg might respond with an understanding nod, whereas a Gestalt therapist would probably

wonder what message the clasping might be conveying, and ask James to repeat and exaggerate this action and to concentrate on the feelings associated with it. Once James had identified and expressed those feelings, the therapist would ask him to elaborate on them.

Frustrating the Client. Because it is not always easy for clients to become aware of hidden feelings, Gestalt therapists use many other methods to promote self-exploration. To help clients give up their maladaptive interpersonal roles and games, for example, Perls deliberately set out to frustrate their efforts to interact with him as they do with others. During individual or group therapy, he put his clients on what he called the "hot seat," where all attention was focused on the client's symptoms, interpersonal games, and resistances so that their meaning and phony elements could be pointed out and explored.

Suppose that James had met with Fritz Perls, and begins the session by saying, "I've really been looking forward to seeing you. I really hope you can help me." Instead of reflecting this feeling or asking James why he feels this way, Perls would probably have focused on the manipulative aspect of the statement, which seems to contain the message, "I expect you to help me without my having to do much." Perls might say, "How do you think I could help you?" Perhaps taken aback, James might respond, "Well, I was hoping you could help me feel less depressed and unhappy." Perls would continue to frustrate what he saw as James' attempt to get a therapist to take responsibility for solving his problems and, in the process, would help James recognize that he tends to avoid taking on that responsibility. Perls might also help James recognize that it is unrealistic to expect that any therapist will have a magical cure for life's problems.

As you might imagine, therapeutic techniques that use confrontation and

deliberate frustration can be powerful motivators, but they can also drive clients away or create negative treatment outcomes if the techniques are not implemented properly and carefully (Lilienfeld, 2007; Sommers-Flanagan & Sommers-Flanagan, 2012).

Existential and Other Humanistic Approaches

A number of other humanistic therapies are also in use by clinical psychologists, and many of them blend person-centered or Gestalt methods with principles from psychodynamic, behavioral, or existential psychology (Ginger & Ginger, 2012; Ladd & Churchill, 2012; Maslow, 1968; May, 1969; Schneider & Krug, 2010; Scholl, McGowan, & Hansen, 2012).

Existential Psychotherapies. Psychodynamic therapist Otto Rank was influential in the development of *existential psychotherapy*. Existential therapists are attracted to Rank's idea that people have a will to find meaning in their lives, and they try to help clients to do that by exploring with them what it means to be alive. Rank's views and methods are rooted in the existential philosophies of Kierkegaard, Nietzsche, Heidegger, and Sartre, which stress the immense freedom that human beings have as they search for meaning in their lives. This freedom can be liberating, but also frightening because it entails exploring profound questions about the purpose of our lives and assuming personal responsibility for dealing with the answers we find. For example, we must confront the fact that our lives will end someday, consider the question of whether life has any real meaning at all, and recognize that although humans have the capacity for extraordinary goodness, they are also capable of extraordinary cruelty.

Existential therapists point out that, rather than facing such potentially terrifying thoughts and questions, many people simply adopt beliefs about life that are passed on to them by their parents, teachers, religious leaders, and others. Adhering to these beliefs is often comforting, but as time goes by some people begin to question their validity. When this happens and they

fully recognize the degree of freedom they have in making sense of the world and of life, it can be like standing at the edge of a cliff; they may become disoriented and experience anxiety disorders, depression, or other psychological problems.

As in person-centered therapy, existential therapists try to understand the client's inner world, frames of reference, and flow of experiences. They do not try to formulate diagnoses or objective descriptions of their clients' problems. Instead, they join in their client's very personal search for meaning (Schneider, 2003). They use relationship-building and empathic responding, as in person-centered therapy, but they may also engage in analysis or interpretation, and use techniques from other approaches that focus on the client's ways of experiencing and relating in the here and now. So, like Gestalt therapists, existential clinicians might comment on a client's body postures, tone of voice, use of language, assumptions, and the like (Schneider & Krug, 2010). In short, their methods are eclectic or integrative and their focus is on each client's struggle to construct their own meanings of existence. Existential therapy may be as brief as a few sessions but is more likely to extend over several months or even a few years (Bugental & Sterling, 1995; Joseph & Murphy, 2013; Schneider 2008).

Motivational Interviewing. *Motivational interviewing* is a humanistic treatment approach derived explicitly from person-centered therapy (Sommers-Flanagan & Sommers-Flanagan, 2012). In motivational interviewing, therapists use reflective listening techniques to call clients' attention to their choices and values (Bohart & Watson, 2011). Often used in substance abuse counseling or in other situations in which clients may have mixed feelings about being in treatment or distrustful of authority, motivational interviewing seeks to meet ambivalence with reflection rather

than with confrontation. It aims to clarify clients' ambivalence regarding change. For example, many clients with drinking problems want to give up alcohol, but are fearful and reluctant about trying to do so. The underlying assumption in motivational interviewing is that if clinicians express empathy and accurately reflect clients' thoughts and feelings, clients will become less defensive. They may also become more aware of discrepancies between their behavior and their deeper values, and that the responsibility for resolving such discrepancies lies with them.

The similarities between reflective responding in client-centered therapy and in motivational interviewing are obvious—both are designed to help clients to see themselves more clearly. However, motivational interviewers are far more active than their person-centered colleagues. They go well beyond active listening and reflection, sometimes purposely overstating or siding with only one side of their clients' ambivalence. Having established a supportive therapeutic relationship, these therapists use subtly directive rather than nondirective methods that gently guide clients toward recognizing their problems, and the role the clients play in perpetuating those problems. Using these insights, motivational interviewers encourage clients to commit themselves to overcoming their ambivalence about change by promoting and reinforcing "change talk." Then, they collaborate with clients in making specific plans for making changes—all the while expressing hope and confidence that a successful outcome is possible. A critical aspect of this approach is not to push for action plans before clients have overcome their ambivalence about the idea of making changes.

Emotion-Focused Therapy. As its name implies, *emotion-focused therapy* emphasizes the role of emotion in human experience. Like motivational interviewing, it is derived from person-centered treatment

principles. Originally known as *process-experiential emotion-focused therapy* (Greenberg, Rice, & Elliott, 1993), this approach views psychological difficulties as stemming from emotional schemes, which are people's organized patterns of emotional responses. Whether working with individuals or couples, emotion-focused therapists seek to provide a warm, empathic, and supportive relationship in which clients are better able to fully experience their emotions, particularly emotions related to vulnerability. They use a variety of specific tasks—including internal dialogue, empty chair, and others borrowed from Gestalt therapy—to facilitate expression of emotions (Watson, Goldman, & Greenberg, 2011). To improve clients' ability to regulate their emotions, emotion-focused therapists help clients become aware of, label, accept, reflect upon, and modify emotions that in the past have led them to think and behave in maladaptive ways (Bohart & Watson, 2011).

The Current Status of Humanistic Psychotherapy

Humanistic psychotherapists such as Carl Rogers are often rated by clinicians as highly influential, yet relatively few therapists identify themselves as humanistic (person-centered, Gestalt, existential, or the like). Among faculty in counseling and freestanding psychology training programs, only about 10% claim this orientation; in university-based clinical psychology programs, the percentage is closer to 5% (Bechtoldt et al., 2001; Norcross & Sayette, 2018). One reason for the discrepancy between humanistic psychology's philosophical influence and its actual use by therapists may be that the humanistic approach avoids "pathologizing" clients. Its proponents assume that even bizarre behavior is understandable from the client's point of view. But if clients do not have a "problem," "deficit," "conflict," "illness," or "pathology," and if therapists are not expected to identify, understand, and find solutions to a problem, what is there for the therapist to do? They can passively support clients' efforts to gain the self-awareness presumed necessary to create change, but to many therapists, humanistic approaches do not allow them to take on the kind of more active therapeutic role they prefer.

Humanistic approaches may lack appeal also because, as we describe in Chapter 7, empirical support for them is not as strong as it is for other forms of psychotherapy. This does not mean that humanistic approaches are inherently unscientific. Indeed, Carl Rogers was among the first to recognize the need for scientific research to substantiate the alleged value of any treatment technique, including his own. Many scholars credit Rogers and Rosalind Dymond-Cartright with conducting the first controlled trial of psychotherapy (Rogers & Dymond, 1954). Rogers was also the first to make

recordings of his therapy sessions, and he conducted some of the first empirical research on the relationship between treatment outcome and therapist characteristics such as empathy and warmth. In fact, he was arguably the first modern scientist practitioner (Sommers-Flanagan & Sommers-Flanagan, 2012).

Still, person-centered therapy and related humanistic treatments can be difficult to study because treatment goals and methods are not clearly articulated in advance. Rather, they emerge from the two-person field that is the therapeutic relationship. It is not surprising, then, that these treatments do not fare as well in empirical outcome studies as do more clearly defined interventions that are focused on specifically targeted symptoms. Perhaps that is why better-specified variations on humanistic therapy, such as motivational interviewing in substance abuse treatment, tend to be evaluated more positively by empirical outcome research.

Despite its shortcomings and apparent lack of popularity, no approach to psychotherapy has done more than the humanistic approach to highlight the importance of the therapeutic relationship (Elliott et al., 2013; Zilcha-Mano, 2017). As we describe in Chapter 7, research on the curative factors in psychotherapy has confirmed that importance. In addition, the humanistic vision of the therapist and client as collaborators rather than as “doctor” and “patient” is attractive to many therapists, especially those who employ relational psychodynamic methods. Even the therapists who employ the behavioral, cognitive, and cognitive behavioral methods described in the next chapter are paying increasing attention to the quality of the therapeutic relationship. So humanistic treatment approaches still have considerable impact. Ironically, this impact is based not so much on their unique identity,

but on the fact that many therapists who use other approaches have adopted a number of humanistic concepts and practices (DeRobertis, 2013).

In Review Humanistic Psychotherapy

Treatment	**Major Goals and Techniques**
Person-centered therapy (Carl Rogers)	Create a therapy relationship featuring unconditional positive regard, empathy, and congruence. Use active listening and reflection to help clients become aware of their true thoughts and feelings, and thus restart blocked self-actualization.
Gestalt therapy (Fritz and Laura Perls)	Use active methods, such as a focus on the immediate present, role-playing, internal dialogues, attention to nonverbal messages, and the empty chair technique to help clients identify the interpersonal games they play, reject phony aspects of themselves, and get in touch with their true thoughts and feelings.
Existential therapy	Use a combination of psychodynamic and person-centered methods to help clients in their potentially frightening search for the meaning of their lives.
Motivational interviewing	Use reflection and other aspects of person-centered therapy but in a more directive way that actively encourages clients to make decisions about how to solve their problems.
Emotion-focused therapy	Use a supportive therapeutic relationship and a combination of directive and nondirective methods to help clients to become aware of and modify emotions associated with their personal and/or interpersonal problems.

Test Yourself

1. In most forms of humanistic psychotherapy, the most important curative factor is thought to be the _______________.

2. True or False?: The first step in most forms of humanistic therapy is to give psychological tests to establish a diagnosis of the client's problems.

3. The most philosophically-based form of humanistic treatment is __________ therapy.

You can find the answers in the Answer Key at the end of the book.

Chapter Summary

Psychodynamic and humanistic psychotherapies share a strong emphasis on the importance of the therapeutic relationship, but they differ in their assumptions about personality organization, psychopathology, and therapeutic technique.

In Freudian psychoanalysis, clients are helped to explore the unconscious wishes, fantasies, impulses, and conflicts that are presumed to lie at the root of their psychological problems. Psychoanalytic treatment is aimed at helping clients gain insight into the unconscious conflicts presumed to underlie their symptoms of disorder. To get at unconscious material, much of which is sexual and aggressive and based in infancy and childhood, Freud used treatment techniques such as free association, analysis of the meaning of dreams, of everyday behaviors, of resistance to treatment, and of the transference appearing in the therapeutic relationship. Interpretations of the meaning of this material help move clients toward insight and understanding.

Neo-Freudians and other psychodynamically oriented therapists developed variations on orthodox Freudian psychoanalysis. Among the most prominent of these methods are psychoanalytically oriented psychotherapy, ego psychology, and object relations therapy. A blend of Sullivan’s interpersonal approach and object relations approaches has led to relational psychodynamic approaches. These approaches remain fundamentally psychodynamic but share with the humanistic approaches a belief in the subjective nature of all relationships. The psychodynamic variations tend to be briefer than classical psychoanalysis and to focus more on current

problems than on sexuality, aggression, and childhood conflicts. They emphasize strengthening ego functions more than analyzing id impulses, more on actively repairing damage from inadequate early caregiver relationships than on gaining insight into them, and more on changing maladaptive interpersonal relationships than on delving into their unconscious origins.

Interpersonal psychotherapy is another approach that owes its origins to Sullivan’s theory. It focuses mainly on helping clients become aware of the interpersonal situations in which their psychological and behavioral problems occur and on helping them develop new ways of handling those situations. This approach enjoys considerable empirical support for its effectiveness, especially in cases of depression.

Humanistic therapies are based on the assumption that people possess inherent tendencies toward psychological growth and that their progress toward developing their potential will resume when obstacles such as conditions of worth are removed through the client’s experience of a supportive therapeutic relationship. These problems are presumed to arise largely from socialization processes that prompt people to distort or suppress genuine feelings and wishes in order to please others, so therapy is aimed at creating a client–therapist relationship in which clients can become more aware and accepting of how they really think and feel.

Therapists using Carl Rogers’ person-centered therapy create this relationship by using reflection and other active listening methods to convey empathy, unconditional positive regard, and congruence as they work with clients. The same goals of self-awareness and growth are sought in a more active and confrontational way through Perls’ Gestalt therapy, whose methods include focusing on the present, having clients role-play suppressed

or disowned aspects of the self, frustrating their efforts at resistance, attending to their nonverbal behavior, and having them engage in dialogues with imaginary versions of significant people in their lives. Existential approaches also stress the unique nature of the therapeutic relationship, but they focus on helping clients recognize and deal with their most basic needs for meaning, purpose, and connection. More recent treatments, such as motivational interviewing and emotion-focused therapy, have been informed by the principles of person-centered therapy.

Psychodynamic approaches have remained popular in clinical psychology. Relatively fewer clinical psychologists have come to identify themselves with the humanistic, person-centered, or existential approaches. Nevertheless, many therapists do integrate some of the basic concepts of these approaches in their clinical work.

9

Cognitive, Behavioral, and Acceptance-Based Psychotherapies

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Contents

Behavior Therapy

Cognitive Therapy

Cognitive Behavior and Acceptance-Based Therapies

Chapter Preview

Here we describe a series of approaches to psychotherapy that grew from learning theory and from cognitive psychology, as well as acceptance approaches that have a long history in Eastern faiths and philosophies. We group them together because they are frequently combined in practice and because they share a strong record of empirical support for their efficacy. Behavior therapists rely on techniques designed to identify and change maladaptive behavior. Cognitive therapists view unhelpful thinking patterns as key to maintaining many disorders, so cognitive therapy is designed to change how clients think about events and themselves. Despite certain differences, the behavioral and cognitive approaches are compatible and are often combined into various forms of cognitive behavior therapy, one of today’s most popular approaches to psychological treatment. Acceptance-based approaches, which are central to acceptance and commitment therapy, dialectical behavior therapy, and mindfulness treatments emphasize the value of accepting thoughts, feelings, and experiences (even negative ones) as part of the human experience and learning how to observe reactions without judging them.

Behavior Therapy

Section Preview Here we describe behavior therapy, which developed out of research on learning. Applicable to numerous psychological problems, behavior therapy techniques are designed to help clients learn to change their problematic behaviors and/or the environmental circumstances that support those behaviors.

Behavior therapy is not a single method but rather a large collection of techniques designed to address people's psychological problems. Included are exposure therapies, behavioral activation and contingency management approaches that build on reinforcement principles, relaxation training, biofeedback, assertiveness training, and many others (Antony & Roemer, 2011a). Many of these techniques, such as exposure and behavioral activation, are applied in treatment programs for a wide variety of disorders. Behavioral techniques are used by theorists from a wide spectrum of clinical orientations to treat both children and adults. They tend to be active approaches that use information about what functions various behaviors serve for a person so as to increase helpful behaviors and decrease unhelpful ones.

Behavior therapy
A collection of learning-based treatment techniques that includes exposure therapies, behavioral activation, and contingency management.

Theoretical Foundations

The key assumption underlying behavioral approaches to therapy is that the behaviors seen in psychological problems develop through the same laws of learning that influence the development of other behaviors. So behaviorists see most disorders not as “things” that people have, but as reflections of how the principles of learning have influenced people to behave in particular situations. Our understanding of these principles of learning has emerged from research on classical conditioning, operant conditioning, and observational learning.

Classical conditioning occurs when a neutral stimulus (such as a musical tone) comes just before or otherwise signals the arrival of another stimulus (such as a pin-prick) that automatically triggers a reflexive response (such as a startle reaction). If the two stimuli are paired often enough, the startle reaction begins to occur in response to the previously neutral musical tone. This learning process usually develops gradually, though in some cases, such as when a small child is startled by a large barking dog, a classically conditioned fear response can occur very quickly (sometimes called one-trial learning) and even become a phobia.

Operant conditioning occurs when certain behaviors are strengthened or weakened by the rewards or punishments that follow those behaviors. For instance, a person who has had bad experiences at parties or other social situations will try to avoid such situations or leave them as soon as possible in order to reduce anxiety. These avoidance or escape behaviors are reinforced by the rewarding sense of relief and anxiety reduction that follows them. These behaviors thus become even more likely in the future, and over

time the person may become extremely socially avoidant, leading to all sorts of problems in dealing with groups and other interpersonal situations. But perhaps not in all group situations: a socially anxious person who avoids parties might interact reasonably well with familiar coworkers. This phenomenon illustrates that the adaptive and maladaptive response patterns we learn can be associated with some situations but not others. When two situations are similar enough that they elicit the same response, *stimulus generalization* has occurred. Another way of saying this is that the person does not psychologically *discriminate* (i.e., recognize a difference) between the situations and instead responds to them as if they were the same. Thus, the child who was frightened by a large white dog may later react with fear to all large dogs, or all white dogs, or maybe even to all dogs.

People learn many of their behaviors through direct experiences with classical conditioning and operant conditioning, but they also learn a lot by watching how others behave and what happens to them as a result. For example, the phenomena of *observational learning* and *vicarious conditioning* were demonstrated powerfully in Bandura and Ross's (1963) famous "Bobo doll" studies. In these studies, children who watched an adult being rewarded after behaving aggressively toward an inflatable "Bobo" doll were themselves significantly more aggressive when placed in a room with the doll than were children who saw nonaggressive behavior being modeled or saw an aggressive model being punished. While the specific link between viewing and then acting aggressively is now understood to be less clear-cut than the early Bobo doll studies suggested (Tedeschi & Quigley, 1996), the basic point about how readily we learn from observing others' reactions still holds.

In short, according to the behavioral approach to personality and

behavior disorders, behavior along the continuum from normal to abnormal can be explained by the same set of learning processes. The behavior therapist’s task is to help clients learn how to modify problematic behaviors and/or learn new and more adaptive alternatives. Crucial to this process is an evaluation of the environment to determine whether helpful contingencies are in place to motivate prompt and reward engaging in healthy behaviors. For instance, depressed people often find few activities rewarding and exhibit a pattern of withdrawal and increased time spent in bed. A therapist using behavioral activation techniques would encourage such clients to plan new activities that would provide more reinforcement. As in most other approaches to therapy, the treatment process begins with assessment of the problem to be solved.

Assessment in Behavior Therapy

Behavior therapy assessment is intended to gather detailed information about a client's problematic behaviors, the environmental circumstances under which those behaviors occur, and the reinforcers and other consequences that maintain the behaviors. The assessment process does not typically employ the projective personality tests described in Chapter 5, and only sometimes uses diagnostic labels. Instead, behavior therapists perform a **functional analysis** or a *functional assessment* (Rummel et al., 2012), which examines four key areas: stimulus, organism, response, and consequence (abbreviated *SORC*). Table 9.1 illustrates the kinds of information that are typically included in such an assessment. We focus in this example on 17-year-old Rachel Jackson's restrictive dieting practices, which we described in Chapter 1 as having begun when she was teased about her weight by some of her new friends. These practices have become increasingly problematic because she has started a maladaptive cycle consisting of hours of restricted eating followed by a loss of control and binge eating. A behavior therapist would want to ask many questions to learn about the factors triggering and maintaining Rachel's eating patterns. More generally, assessment is focused on relevant problematic behaviors and is usually integrated with collaboratively agreed-upon treatment goals (Iwata, DeLeon, & Roscoe, 2013; Spiegler & Guevremont, 2010).

Table 9.1 Areas Assessed in Functional Analysis of Behavior

The information gathered in functional analyses may come from structured interviews, objective personality tests, behavioral rating scales, and observations.

Area Assessed	General Examples	Specific Examples for a Client Diagnosed with Bulimia (Binging/Purging Type)
Stimulus	Antecedent conditions and environmental triggers that elicit behavior	Watching commercials about food, selecting clothing, walking by the refrigerator, smelling chocolate, hearing her parents arguing
Organism (person)	Internal physiological responses, emotions, and cognitions	Sensation of hunger, anxiety, concern about weight, worry about being fat, anger over being deprived, fears she might lose control
Response	Overt behavior engaged in by the person	Avoidance of food for a few hours (adding to feeling of deprivation), followed by binging
Consequences	What happens as a result of the behavior	Satiation, increase in guilt and anxiety about weight gain, and renewed plans to restrict eating

Functional analysis
Gathering information about the personal and environmental factors that trigger and support a client's adaptive and maladaptive behaviors.

Notice that Table 9.1 includes assessment of Rachel's cognitions and emotions, as well as of her observable behaviors. Behaviorally oriented clinicians who adopt a strict behavioral view of disorder do not focus much on cognitive variables, but cognitive behavioral clinicians, who prefer a more comprehensive view of the causes of behavior, place greater emphasis on those variables (Antony & Roemer, 2011a). As described later, these cognitive and cognitive behavioral clinicians see their clients' learned patterns of thinking as important causes of normal and abnormal behavior, causes that must be examined carefully and, if maladaptive, changed.

The *"ABC"* approach is another common method of conducting functional analysis, and involves identifying the Antecedents (triggers) of behavior, the nature of the Behavior itself, and the Consequences of the behavior. Often the short-term and long-term consequences are considered separately in order to clarify that many behaviors are reinforcing in the short term but punishing and problematic over time. For example, Rachel's father James' drinking could temporarily reduce his anxiety about being unemployed, but as it increased it began to interfere with his ability to find a new job, and became a frequent source of conflict with his wife Lena. As illustrated in Table 9.2, a behavior therapist might seek to better understand this pattern by asking James to track his drinking episodes using the ABC approach.

Table 9.2 An Example of an ABC Analysis of Problematic Drinking Patterns Data for an ABC analysis can come from many sources, including the self-monitoring methods described in Chapter 4.

		Short-term	Long-term

Antecedent	Behavior	Consequences	Consequences
Argument with Lena.	Meet friend at a local bar, drink 6 beers.	Forget for a while about marital problems and unemployment.	Was hungover so didn't look for a job the next day, wasted more money he doesn't have, and Lena is now even angrier.

Behavior therapists are especially likely to use structured interviews and objectively scored, quantitative assessment methods, such as behavioral rating forms. These measures establish the precise nature of a client's problems and also provide an empirical baseline level of maladaptive behavior. As therapy progresses, the same measures may be administered again to assess and document client progress (see, for example, Figure 3.3 in Chapter 3). If required for insurance reimbursement purposes, behavioral clinicians may assign a *DSM* label to their clients, but diagnostic labeling is generally not the focus of behavioral assessment.

Because behavioral treatments developed within an empirical tradition, behaviorally oriented clinicians tend to have a strong commitment to research. Even if they do not conduct that research themselves, they believe that their therapy methods should be guided by the results of empirical research on learning. They also place a high value on the evaluation of treatment techniques. Behavior therapists are particularly likely to employ assessment instruments and treatment techniques whose efficacy has been established by the results of controlled research.

Role of the Therapist

Behavior therapists also recognize the importance of a good therapeutic relationship, so they are empathic and supportive in response to clients' feelings of anxiety, shame, hopelessness, distress, or confusion. However, in contrast to humanistic therapists who see the client–therapist relationship itself as creating change, behavior therapists see it as the supportive context in which specific techniques can operate to create change. Therapeutic benefits occur when clients make changes in their environments (e.g., by reducing exposure to triggers), internal responses (e.g., by learning relaxation to lower levels of arousal), and overt behaviors (e.g., by practicing conversational skills and reducing avoidance of feared situations). Accordingly, behavior therapists focus actively and directly on these factors in therapy (Newman, 2013; Spiegler & Guevremont, 2010). They also play an educational role, explaining the theory behind what they do in ways the client can understand. Ultimately, they hope to establish the client as collaborator in a systematic analysis of behavior and its consequences.

Goals of Behavior Therapy

The primary goal of the behavior therapist is to help the client modify maladaptive overt behaviors as well as the cognitions, physical changes, and emotions that accompany those behaviors, and the environmental contingencies that make it hard to sustain healthy, adaptive choices. Treatment can proceed without exploring early childhood experiences, unconscious processes, inner conflicts, or the like. In short, in behavior therapy, it is not critical to know the details of how a maladaptive behavior disorder originated; it is enough to know how it is being maintained and how it can be changed.

Clinical Applications

Although built around a general learning model, behavior therapy is applied in a wide variety of treatment packages, each tailored to address particular sets of problematic behaviors. We do not have space to describe all the behavioral treatment techniques that can be combined in these packages, but in the following sections we introduce several of the most prominent and widely used examples. A number of sources provide much more detail about behavior therapy techniques (e.g., Antony & Roemer, 2011a, b; Corey, 2017; Emmelkamp, 2013; Hersen, 2002; Miller, Rathus, Linehan, & Swenson, 2006; Murdock, 2004; O'Donahue & Fisher, 2012; Spiegler & Guevremont, 2010).

Exposure Techniques

Exposure treatments entail facing and interacting with frightening stimuli, such as a dog or a small enclosed space. The goal is to help clients discover that the terrible outcomes they fear do not occur and that they can remain in a feared situation even when they are anxious. Thus, exposures are designed to provoke anxiety in a way that helps clients gain a greater sense of mastery. As clients learn that they can cope with anxiety, recognizing that it is “uncomfortable but not dangerous,” the anxiety typically starts to decline on its own, a process called *habituation*. With time and repeated exposure, clients get used to the very situations that once terrified them and are no longer as fearful. The process of habituation occurs in part as peak physiological arousal declines over time and the conditioned stimulus, such as a dog, is no longer reliably associated with the conditioned fear response. This process is called *extinction* (Abramowitz, 2013).

Exposure treatments
Arranging for clients to have extended contact with a feared situation so that they can gain mastery over it and discover that it is not harmful.

Recent research suggests that the key to the success of exposure techniques is less about the extent to which anxiety declines during exposure and more about the client’s willingness to tolerate rather than avoid anxiety,

and thus learn mastery from the experience. More specifically, the effectiveness of exposure depends on the extent to which *expectancy violation* occurs; that is, the degree to which clients learn that the negative outcomes they expect do not materialize (Craske et al., 2014). So, if a person with social anxiety disorder thinks he will "never survive" the embarrassment of forgetting a part of his speech, or a person with panic disorder believes she will faint if she starts to panic while at a restaurant, these are the very activities they will be encouraged to try in order to directly test and counter their fearful beliefs. When a client can do this, anxiety may not entirely disappear, but it will lose its power to control the client's life. In other words, the old admonition to "face your fears" has a strong basis in science.

Research by Dr. Michelle Craske, Director of the Anxiety and Depression Research Center at UCLA has helped clinicians maximize the benefits of exposure therapy for anxiety and other disorders.

(Source: Supplied with permission of Dr. Michelle Craske.)

Exposure treatments can take many forms, depending on the problems being addressed. This is especially true in the case of anxiety disorders. A person with social anxiety disorder may need to return to the party situations that she's been avoiding, while a person who fears driving over bridges may have to practice doing so, and a person with obsessive-compulsive disorder (OCD) may need to repeatedly leave his house without double checking that he remembered to lock the door.

Early Approaches to Exposure: Systematic Desensitization. The emphasis in modern exposure therapies on helping clients learn to tolerate anxiety and not avoid anxious feelings came about because research suggests that they are more effective than earlier versions whose aim was to eliminate anxiety responses altogether (see Craske et al., 2008). The most prominent of these early exposure techniques, called *systematic desensitization,* was developed in the 1950s by Joseph Wolpe, a South African psychiatrist. His approach was based on research with cats that had been repeatedly shocked in a special cage. They learned to fear that cage, resisted being put in it, and refused to eat while there. Wolpe reasoned that if conditioned anxiety could inhibit eating, perhaps eating might inhibit conditioned anxiety through the principle of *reciprocal inhibition.* According to Wolpe (1958): "If a response antagonistic to anxiety can be made to occur in the presence of anxiety-evoking stimuli so that it is accompanied by a complete or partial suppression of the anxiety responses, the bond between these stimuli and the anxiety

responses will be weakened" (p. 71). In fact, when he "counter-conditioned" the cats' fear by hand-feeding them in cages that were placed closer and closer to where their anxiety had been learned, most animals showed greatly diminished emotional reactions when later placed in the previously feared cage.

Applying these methods to people with phobias, Wolpe taught clients to use **progressive relaxation training (PRT)** to create a mental and physical state that is incompatible with anxiety. After learning PRT, his clients worked with Wolpe to create a graduated list, or hierarchy, of increasingly anxiety-provoking situations. Desensitization began by having the client achieve deep relaxation and then imagine the least threatening situation on the anxiety hierarchy. If anxiety occurred, the imaginal exposure was paused until the client regained relaxation. This pairing of the imagined feared event and relaxation was repeated until the feared situation no longer created distress, at which point the client would imagine the next item in the hierarchy.

Progressive relaxation training (PRT)
A set of muscle tension and release procedures designed to create feelings of relaxation that are incompatible with anxiety.

The progressive relaxation training that Wolpe used in systematic desensitization was an abbreviated version of a method pioneered by American physician and physiologist Edmund Jacobson (1938). Often also called *progressive muscle relaxation*, or *PMR*, PRT involves tensing and then

releasing 16 different muscle groups, one at a time, while focusing on the sensations of relaxation that follow (Hazlett-Stevens & Bernstein, 2021).

Try this You can get an idea of what the training feels like by clenching your fist for about 7 seconds and then abruptly releasing the tension and noticing the difference. With sufficient practice, clients can learn to relax themselves and lower their arousal level, and as they become more skillful, the process is shortened.

PRT is occasionally used by itself, but more often in conjunction with other behavioral and cognitive techniques in the successful treatment of problems such as hypertension, headache, insomnia, and the side effects of chemotherapy. When combined with the exposure and other treatments discussed in this chapter, it can also contribute to improvement in cases of mild to moderate depression, and several types of anxiety (Hazlett-Stevens & Bernstein, 2012, 2021), including in older adults (Klainin-Yobas et al., 2015).

The mechanisms underlying relaxation training have been compared to those of mindfulness training, which is discussed later in this chapter. Both techniques encourage nonjudgmental awareness of bodily experiences.

Modern Exposure Treatments. In exposure techniques known as *flooding*, clients are asked from the outset to do the things that scare them the most, as when a person who fears heights starts treatment by standing for long periods at a low railing on the roof of a tall building. However, most forms of exposure therapy today involve methods that are more like the gradual ones seen in desensitization. So a client who fears heights might be asked to first practice standing on the lowest step of a ladder and then work her way upward, one rung at a time over several weeks, and then tackle even more threatening situations. This example of gradual methods illustrates the use of *in vivo* exposure, meaning that the client actually enters the feared

situation, but gradual exposure can also be *imaginal*, meaning that the client either imagines increasingly frightening stimuli, or is exposed to them using virtual reality technology (e.g., Miloff et al., 2019; see Chapter 4). *In vivo* exposures are the most common and generally preferred options, but imaginal or virtual reality exposures are especially useful when it is difficult or impractical to put clients in certain situations, such as turbulence during air travel.

Some problems dictate that clients be exposed not to external stimuli but to the internal sensations that elicit anxiety. For instance, many clients with panic disorder fear the sensations of increasing heart rate, because they think it signals the start of a panic attack or even a heart attack. To help these clients learn that they can tolerate these uncomfortable but not dangerous feelings, they are assigned to create *interoceptive exposures* in which they spend a minute or so engaging in exercises to make their heart race or to bring on feelings of dizziness.

Regardless of the type of exposure, the treatment process is not coercive. The goal is to help the client gain mastery and control in feared situations, thus providing a greater sense of *self-efficacy*, or confidence in their ability to manage their fears. The exposure sessions also expand clients' choices in the sense that they no longer have to avoid frightening situations. The effectiveness of exposure therapies appears to be greater when therapists follow certain guidelines. These include: (a) making the exposure predictable by giving the client control over its intensity and duration; (b) encouraging clients to tolerate somewhat longer and more intense exposures over time; (c) scheduling exposures close together in time (e.g., daily, rather than weekly, practice); (d) varying the exposure stimuli (e.g., using differently colored harmless snakes, rather than just one); and (e) conducting exposures in varied

settings (Antony & Roemer, 2011b). There are even recent efforts to enhance the effects of exposure by adding non-invasive brain stimulation, though this work is still in its earliest stages (Nuñez, Zinbarg, & Mittal, 2019).

Notice that many of these guidelines serve to increase the chances that the fear-reducing effects of exposure will generalize to a wide variety of previously feared situations. The goal is not just to help a client tolerate one particular cat while in the therapist's office; it is to equip clients to manage encounters with many different kinds of cats in many different settings, including when the therapist is not present. Indeed, successful exposure treatment often includes *overlearning*, a process of exposing oneself to even more extreme versions of the feared situation than one might ever encounter in daily life. For instance, a client whose OCD includes cleaning compulsions is likely to want everything in his home to be clean and arranged "just right." Exposure treatment might include having him purposely spill a drink on his kitchen floor and not clean it up for days so he learns he can tolerate the anxiety. While most of us would wipe up a spilled drink immediately, learning that one can tolerate even this big mess provides a sense of accomplishment. Successful overlearning is a bit like an insurance policy that bolsters clients' confidence in their ability to manage the typical challenges that they *are* likely to encounter (Shibata et al., 2017): "If I can handle a spilled drink for 4 days, I can surely handle not disinfecting my counters five times a day."

Gradual exposure starts with the therapist explaining the theory or rationale behind the treatment, and ensuring that the client understands, accepts, and is willing to cooperate in the procedures. The next step is for the therapist and client to work together to create an individually-tailored hierarchy of increasingly challenging fear exposures, beginning with very

easy ones and working up to those at levels that are extreme enough to promote overlearning (see Table 9.3). Of course, the activities listed must be those that the client can actually try, so there is no point in planning for a speech-anxious client to eventually give a talk to 10,000 people if that situation cannot feasibly be arranged. Sometimes, though, therapists will arrange for clinical assistants to act out certain roles to create increasingly anxiety-provoking social scenarios. Role-playing can also be done in group treatment for social anxiety by asking one client to appear uninterested in another client's attempts at making conversation at a mock party.

Table 9.3 Sample Exposure Treatment Hierarchies
As shown here, the first step in an exposure treatment hierarchy is usually at a fear level that the client rates at around 3 (out of 10). The client then works upward until reaching the most feared activities.

Fear of Driving	
Anticipated Fear Level (1–10)	**Exposure Activity**
10	Merge on and off busy highways alone during rush hour (with no GPS).
9	Drive alone across a busy bridge.
8	Drive alone on the highway to a new destination (following GPS).
7	Drive on the highway to a new destination (following GPS) with a friend to help navigate.

7	Drive alone to a new destination (following GPS)—no highway driving.
6	Drive to a new destination (following GPS) with a friend to help navigate—no highway driving.
5	Drive alone down a suburban street during the morning commute.
4	Drive down a suburban street during the morning commute with a friend.
4	Drive alone down a quiet suburban street at night.
3	Drive down a quiet suburban street at night with a close friend in the car.

Fear of Being Negatively Evaluated by Others

Anticipated Fear Level (1–10)	**Exposure Activity**
10	Intentionally give the wrong answer in a large lecture class.
10	Spill a drink on your own shirt while talking to a new person.
9	Ask X (a potential romantic interest) out for coffee.
7	Go to a party where you only know a few people.
7	Raise your hand in a class discussion to offer an opinion that could be controversial.
6	Ask Y (an acquaintance from psychology class) out for

	coffee.
5	Raise your hand in class when you feel mostly but not totally sure of the answer to a question.
4	Go out to dinner with friends.
3	Say hello to a person who sits nearby in history class (even when you don’t know the person’s name).
3	Say hello to a stranger at the bus stop.

A Case Example of Exposure Treatment

As we describe in Chapter 8, Rachel Jackson's mother, Lena, began a course of psychotherapy because of panic attacks associated with her marital, parenting, occupational, and financial problems. Her therapist, Dr. Kim, used psychoanalytic treatment methods, but as described in Chapter 2, problems can be addressed from many different theoretical points of view. To illustrate this point, let's consider how a behavior therapist might have applied exposure treatment in Lena's case (typically a preferred approach for panic attacks, given the strong research support for this intervention).

Lena reported having one panic attack at home, two at work, one while grocery shopping, and one while driving. Since those latter attacks, Lena has been asking Rachel to do the grocery shopping and avoids driving alone whenever possible for fear of having another attack. She has to drive to work, though, so she now carries a bottle of anti-anxiety medication with her at all times. A behavior therapist would see this *safety behavior* (Blakey & Abramowitz, 2016) as potentially problematic because carrying the pills is a form of avoidance that prevents Lena from learning that she can tolerate anxiety when it occurs and that it will diminish on its own without medication. Indeed, because carrying the pills is reinforced in the short term because it reduces Lena's fear of a panic attack, she may soon become dependent on having the pills handy in more and more situations.

A behavior therapist would help Lena to build the exposure hierarchy shown in Table 9.4. It is designed to reduce her avoidant behaviors and increase her ability to tolerate anxiety, thereby reducing her fear of panic attacks, as well as the attacks themselves. Lena would also likely be assigned

to practice interoceptive exposures in which she performs a minute of physical exercise or drinks a lot of caffeine in order to noticeably increase her heart rate and discover that a heart attack will not occur.

Table 9.4 An Exposure Hierarchy to Reduce Fear of Panic

Anticipated Fear Level (1–10)	**Exposure Activity**
10	Doing the full grocery shopping alone.
9	Driving alone more than an hour from home.
8	Driving more than an hour from home with her son (who Lena feels is too young to be much help if she has a panic attack).
7	Driving more than an hour from home with Rachel.
7	Driving alone to a familiar destination (other than work).
6	Doing the full grocery shopping with Rachel.
5	Going to work all day with no benzodiazepine pills.
4	Picking up one item from the grocery store alone.
3	Picking up one item from the grocery store

	with Rachel.
3	Going to a meeting at work without benzodiazepine pills in hand.

Exposure and Response Prevention. An important variant of exposure, called *response prevention* is commonly used in the treatment of OCD or other problems in which clients seek to counter their anxiety by performing some kind of harm-avoidance ritual. For instance, an obsessional worry about burglars might lead to repeated checks that the front door is locked, or a fear of contamination by dangerous germs may lead to abnormally long and careful showers and repeated hand washing. Response prevention in such cases involves clients exposing themselves to feared situations, thoughts, and images but not being allowed to perform the rituals they normally use to reduce anxiety (Antony & Roemer, 2011a; Foa, Yadin, & Lichner, 2012). The idea behind this approach is that with continued exposure to feared stimuli, without the ritual, and without harmful consequences, those stimuli gradually become less anxiety provoking. The following excerpt from a response prevention exposure session will give you an idea of how the treatment was done with a client who was disabled by cleaning obsessions and compulsions (Steketee & Foa, 1985). Notice how the therapist guides and encourages the client to confront a frightening situation (a dead cat on the street) and to stay in contact with it until she learns that she can tolerate the anxiety. This is a clear example of the use of overlearning goals.

THERAPIST: (Outside the office.) There it is, behind the car. Let's go and touch the curb and street next to it. I don't think that you need

to touch it directly because it's a bit smelly, but I want you to step next to it, then touch the sole of your shoe.

CLIENT: Yuck! It's really dead. It's gross!

T: Yeah, it is a bit gross, but it's also just a dead cat if you think about it plainly. What harm can it cause?

C: I don't know. Suppose I get germs on my hand?

T: What sort of germs?

C: Dead cat germs.

T: What kind are they?

C: I don't know. Just germs.

T: Like the bathroom germs that we've already handled?

C: Sort of. People don't go around touching dead cats.

T: They also don't go running home to shower or alcohol the inside of their car. It's time to get over this. Now, come on over and I'll do it first. (*Client follows.*) OK. Touch the curb and the street. Here's a stone you can carry with you and a piece of paper from under its tail. Go ahead, take it.

C: (*Looking quite uncomfortable*) Ugh!

T: We'll both hold them. Now, touch it to your front and your skirt, and your face and hair. Like this. That's good. What's your anxiety level?

C: Ugh! 99. I'd say 100, but it's just short of panic. If you weren't here, it'd be 100.

T: You know from past experience that this will be much easier in a while. Just stay with it and we'll wait here. You're doing fine.

C: (*A few minutes pass in which she looks very upset*.) Would you do this if it weren't for me?

T: Yes, if this were my car and I dropped my keys here, I'd just pick them up and go on.

C: You wouldn't have to wash them?

T: No. Dead animals aren't delightful, but they're part of the world we live in. What are the odds that we'll get ill from this?

C: Very small, I guess… I feel a little bit better than at first. It's about 90 now.

T: Good! Just stay with it now.

The session continues for another 45 minutes as the client recognizes that she can tolerate the distress and that the feared outcomes do not occur. During this period, conversation focuses generally on the feared situation and the client's reactions to it. The therapist inquires about the client's anxiety level approximately every 10 minutes.

T: How do you feel now?

C: Well, it is easier, but I sure don't feel great.

T: Can you put a number on it?

C: About 55 or 60, I'd say.

T: You worked hard today. You must be tired. Let's stop now. I want you to take this stick and pebble with you so that you continue to be contaminated. You can keep them in your pocket and touch

them frequently during the day. I want you to contaminate your office at work and your apartment with them. Touch them to everything around, including everything in the kitchen, chairs, your bed, and the clothes in your dresser. Oh, also, I'd like you to drive your car past this spot on your way to and from work. Can you do that?

C: I suppose so. The trouble is going home with all of this dirt.

T: Why don't you call your husband and plan to get home after he does, so he can be around to help you. Remember, you can always call me if you have any trouble.

C: Yeah. That's a good idea. I'll just leave work after he does. See you tomorrow.

(*Source:* Franklin, M. E., & Foa, E. B. (2014). Obsessive-compulsive disorder. In D. H. Barlow (Ed.), *Clinical handbook of psychological disorders: A step-by-step treatment manual*. New York, NY: Guilford. Copyright 2014 by Guilford Press. Adapted with permission.)

Thinking Scientifically Should EMDR Be a Treatment of Choice for Posttraumatic Stress Disorder?

There is ongoing debate in clinical psychology about whether a treatment called *eye movement desensitization and reprocessing* (*EMDR*) should be considered as one of the exposure treatments described above, and whether its effects are comparable to those of the other techniques. EMDR was developed in the 1980s by clinical psychologist Francine Shapiro (1948-2019), and first used

mainly to treat posttraumatic stress disorder (PTSD). EMDR involves exposing PTSD clients to traumatic or other distressing memories while the clients receive “bilateral stimulation” to encourage attention to both internal and external events. This stimulation is usually created by side-to-side eye movements as the client follows the therapist’s finger or hand as it moves back and forth in front of the client’s eyes (Shapiro, 1989, 1995, 2017).

The treatment is based on the idea that memories of past trauma have not been adequately “processed,” and that EMDR can correct this problem. Dr. Shapiro’s explanations of how the treatment works have never been entirely clear, as when she wrote that it operates by “… catalyzing a rebalancing of the nervous system, and this leads to a shifting of information that is dysfunctionally locked in the nervous system” (Shapiro, 1995, p. 30). Such vague terminology immediately generated considerable skepticism among clinical scientists. Perhaps, they say, EMDR works simply by exposing clients to traumatic memories or through other mechanisms, including placebo effects. If exposure *is* the main mechanism, then the bilateral stimulation created by eye movements or other means should not be necessary.

What am I being asked to believe?

The proponents of EMDR claim not only that EMDR has beneficial effects on PTSD symptoms and many other clinical problems, but that the repetitive bilateral movements are indeed a key treatment mechanism.

What kind of evidence is available to support the claim?

There is now considerable evidence that the effects of EMDR are often similar to those of established exposure therapies in the treatment of PTSD symptoms (e.g., Bisson et al., 2007; Seidler & Wagner, 2006). The evidence for its effectiveness in treating other problems is not as strong (see https://www.quackwatch.org/01QuackeryRelatedTopics/emdr.html).

How important are side-to-side eye movements in the success of EMDR? One meta-analysis of studies comparing EMDR conducted with and without eye movements found no significant differences (Davidson & Parker, 2001). This evidence led clinical scientists to conclude that EMDR works through the same mechanisms as other exposure therapies. But then, as always happens in science, additional evidence became available. Some of it—from a new meta-analysis that used a different and somewhat improved methodology—suggested that EMDR with eye movements showed better results than EMDR without those movements (Lee & Cuijpers, 2013). At about the same time, other studies were offering convincing evidence that, if eye movements are involved in treatment effects, the movements don't have to be side-to-side. Moving the eyes up and down appears to be just as effective (Gunter & Bodner, 2008; Van den Hout & Engelhard, 2012).

Are there alternative ways to interpret the evidence, including those that my biases and preconceptions might have kept me from seeing?

How might we understand these seemingly discrepant findings? First, we have to recognize that EMDR is made up of several components,

and that the many studies supporting the efficacy of EMDR as a useful, exposure-based treatment option for trauma-relevant symptoms tell us little or nothing about exactly which of those components are responsible for that efficacy.

One research team's extensive review of the literature, and an interesting series of experiments, suggest a new way of approaching the question of how EMDR works (Van den Hout & Engelhard, 2012). The team did not start by asking whether eye movements matter or not; instead, they considered the question of whether it is important for clients to be doing a second task while recalling traumatic memories. They suggest that if recalling an emotional memory competes with another task that requires some working memory, that emotional memory will be less vivid when it is reconsolidated and put back into long-term storage (Van den Hout & Engelhard, 2012, p. 728). Because doing this "dual task" leaves less working memory capacity available to support reconstruction of a vivid emotional memory, that memory's emotional impact will be reduced. If this description is correct, it may be that eye movements are just one example of the kind of "dual task" that can serve to tax a client's working memory capacity (van Veen, Kang, & van Schie, 2019).

What additional evidence would help to evaluate the alternatives?

This new line of research suggests a potentially valuable way to make sense of conflicting findings about the importance of eye movements, but many questions remain. For one thing, it will be important to evaluate the boundary conditions of the working memory

explanation. To what extent does working memory need to be taxed, and are there other kinds of dual tasks that might be even better at doing so? Would those other kinds of dual tasks work for all clinical populations and all problems? How can we explain why some studies did not find eye movements to be beneficial while others did? How do demands on working memory compare between clients being treated with EMDR versus more traditional, well-established, exposure-based cognitive behavior therapies?

What conclusions are most reasonable given the kind of evidence available?

At this stage, it seems reasonable to conclude that EMDR often achieves effects that are similar to those of exposure-based cognitive behavior therapies, and thus offers another treatment option for clinicians and clients. Further, it seems clear that although exposure is an important part of how EMDR achieves its effects, it may be possible to increase its effectiveness by adding a second, memory-taxing task. More research is needed before we can be confident about this conclusion, but there is no doubt that claims for the vital importance of eye movements, and especially side-to-side movements, in producing EMDR's effects are not well supported by current evidence. The controversy over EMDR highlights the distinction between showing that a treatment can help people and knowing the mechanisms that drive its benefits.

Social Skills Training

Some psychological disorders may develop partly because people lack the social skills necessary to establish and maintain satisfying interpersonal relationships and other social reinforcers. Accordingly, behavior therapists sometimes include a *social skills training* component in the treatment of adult disorders such as schizophrenia, depression, anxiety, and a variety of childhood disorders, including delinquency, attention-deficit hyperactivity disorder, autistic spectrum disorders, and even behavior problems resulting from fetal alcohol syndrome (Granholm et al., 2014; Kinnaman & Bellack, 2012; Thase, 2012).

Social skills training encompasses many techniques, depending on the nature of the difficulties, from teaching people how to shake hands and make eye contact to ordering food in a restaurant and engaging in casual conversations. A form of social skills training called **assertiveness training** is especially valuable for use with adults whose inability to effectively express their needs and wishes leads to resentment, aggression, or depression. All too often, these people know what they would *like* to say and do in various social situations but, because of thoughts such as “I have no right to make a fuss” or “He won’t like me if I object,” they suffer in silence. Assertiveness training is designed to teach clients how to express themselves appropriately if they do not already have the skills to do so, and eliminate cognitive obstacles to clear self-expression. Although initially focused on training in the “refusal skills” many clients need to ward off unreasonable requests, assertiveness training is now also aimed at promoting a broader range of social skills, including engaging in interpersonal problem-solving,

and appropriately responding to emotional provocations (e.g., Speed, Goldstein, & Goldfried, 2018). Because of its demonstrated effectiveness, social skills training has become a standard component of broader treatments for schizophrenia, depression, and several other disorders.

Social skills training
Procedures designed to improve the skills clients need to interact successfully with other people.

Assertiveness training
A form of social skills training focused on helping clients to effectively express their needs and wishes.

Behavioral Activation and Activity Scheduling

The idea behind **behavioral activation** is to help clients engage in behaviors that will provide more reinforcement from the environment and move clients closer to achieving their goals. Behavioral activation is built on simple but powerful assumptions, including that people are likely to become and stay depressed, for instance, if they are not engaged in activities that give them pleasure or a sense of mastery. The goal is not that clients should try to have fun all the time, but that they should figure out how to engage with their environment in ways that are reinforcing and improve their mood and sense of accomplishment.

> **Behavioral activation**
> A behavioral treatment method to help clients engage more often in behaviors that will provide reinforcement from the environment.

Think about Rachel Jackson's father, James, who is experiencing depressive symptoms associated with his unemployment. A therapist using behavioral activation techniques would likely encourage him to first track his mood as he engages in various activities throughout a typical week to learn what factors make him feel a little better or a little worse. The next steps would be to use information from this "mood log," combined with discussion about James' goals, to schedule activities designed to help him increase his experiences of pleasure and mastery. There is no expectation that James will

immediately feel motivated to change his behavior, because lack of motivation is a common symptom of depression. The hope instead is that by taking small steps to increase reinforcing activities, James will gradually start to feel better and, in turn, be more motivated to take additional steps toward further improvement.

Behavioral activation and activity scheduling programs, on their own or as a component of a larger set of cognitive behavioral approaches, have shown impressive results for clients like James who have been withdrawn in the context of depression, social anxiety disorder, or grief (Ekers et al., 2014).

Aversion Therapy and Punishment

Aversion therapy is a set of learning-based techniques in which painful or unpleasant stimuli are used to decrease the probability of unwanted behaviors, such as drug abuse, alcohol use disorders, smoking, and non-consensual sexual practices. Following classical conditioning principles, most aversion methods pair a noxious stimulus such as electric shock with stimuli that normally elicit problematic behavior. So, for example, a person who is dependent on alcohol would be exposed to a foul odor as he sits at a simulated bar, looking at (and smelling) a glass of his favorite alcoholic drink. Ideally, continued pairings would decrease the attractiveness of the alcohol or other eliciting stimulus until the unwanted behavior is reduced, if not eliminated. The same goal can be sought through the use of *punishment* in operant conditioning programs. Here, electric shock or some other aversive stimulus is delivered just after the client performs the problematic behavior (e.g., taking a sip of alcohol). As you might imagine, there is considerable debate among clinical scientists about the ethics of aversion and punishment methods, as well as about their effectiveness. Accordingly, these techniques are rarely used, usually as a last resort to control dangerous behavior (such as non-consensual sexual practices) that has not responded to less drastic methods.

In addition to those described here, numerous other treatment techniques have developed out of the behavioral tradition (see the In Review section below).

Aversion therapy

A set of techniques that employ painful or unpleasant stimuli to decrease unwanted behaviors.

A Case Example of Behavior Therapy

Here is an example of the application of behavior therapy in the case of maladaptive behavior in a child and in the child's family. The case involves one of James Jackson's younger brothers, Robert. Like James' other siblings mentioned in Chapter 8, Robert had a successful career, but had always been somewhat passive and lacking in assertiveness, especially in conflict situations. These traits were partly responsible for the breakup of his marriage; his wife called him a "wimp" and a "doormat." She left Robert and their then 2-year-old daughter, Ella, and moved out of the country.

Robert moved in with his parents in order to get help with raising Ella, but over the next 2 years, her behavior became increasingly disturbing. Now 4 years old, Ella refused to follow directions, screamed if she did not get what she wanted, and broke toys when she got angry. Robert and his parents regretted (and Robert felt guilty) that Ella no longer had contact with her mother, and his mother, especially, tried to compensate for this loss by doting on Ella and giving her anything she wanted. Like any bright child, Ella soon figured out that if she could not get what she wanted from her father, she could get it from her grandmother. A typical example of this pattern occurred one day when Ella was jumping up and down on the couch. Robert said, "Ella, please don't jump on the couch—you might fall and get hurt." He remained firm and did not relent even when Ella cried and begged to be allowed to jump, so he was understandably annoyed when, later that day, his mother let Ella jump on the couch. Robert realized that both he and his mother would have to be more consistent in setting limits if they were going to see improvements in Ella's behavior. However, his characteristic

unassertiveness led him to worry about how to share his wishes with her in a way that would not upset his mother or hurt her feelings, so he did not say anything. Ella continued to get her way with her grandmother and her disruptive behaviors continued to worsen.

Dr. Jill Hesse (not her real name), a behavior therapist who worked with Robert and his family, recognized immediately that she needed to help Robert develop assertiveness skills to help him communicate effectively with his mother. Robert agreed, and with Dr. Hesse's help began to role-play more direct communication skills. For example, Robert would state what he would like to say to his mother and Dr. Hesse would give feedback on how that statement might be perceived or ways in which it was unclear. This process continued until both Robert and Dr. Hesse felt his statements would be effective with his mother.

The next step was to try these assertive communication skills with his mother. Robert's first attempt did not work. He said "Mom, I would like to talk to you about Ella's behavior and how she keeps pushing us until she gets her way. We shouldn't always give in to her demands." As it turned out, part of this statement was appropriate (i.e., Robert mentioned a specific aspect of the problem), but part of it was not helpful because it did not give Robert's mother direct feedback on what she needed to change. In the past, when Robert tried this strategy, his mother would say "Oh yes, dear. I completely agree," but then would continue to indulge Ella.

Robert came up with a better plan, and at a later therapy session was able to practice the following statements: "Mom, I want to thank you and Dad for helping me raise Ella. You mean the world to us. With the help of my therapist, I have a new strategy for dealing with Ella's behavior when she tries to get away with things that she knows are not allowed. For example,

when she jumps on the couch, I say ‘No’ and even when she begs and cries, I remain firm with this decision. The thing is, I need your help with this plan. So, when you hear limits that I’ve set with Ella, you need to honor those limits and follow them with Ella—even if you don’t completely agree. Do you think you can do that? Because, I really appreciate all of your help with Ella and I know that with both you and me being on the same team—we’ll be able to help Ella improve her behavior now and when she is older.” Dr. Hesse agreed that these statements would be much more effective than the initial ones because they provide clear and direct guidance for his mother, while recognizing her valuable contributions to the family in a way that made it more likely that she would “hear” the feedback and not become defensive.

After Robert practiced these statements a few more times with Dr. Hesse, they role-played a conversation that might ensue if his mother reacted negatively. This role-play allowed Robert to prepare for the possibility that his mother would become defensive or angry, and to discuss how to handle that situation. Dr. Hesse asked Robert to describe the worst, best, and most likely outcome of his upcoming conversation with his mother and they role-played all three scenarios (starting with the best one, so as to build Robert’s confidence). Once they both felt confident about the appropriateness of Robert’s planned strategies, Dr. Hesse gave him the homework assignment of once again discussing this topic with his mother. Because Robert had mentioned that his mother is not very open to discussions when she is hungry or in a hurry, Dr. Hesse suggested that he should raise the topic of Ella after brunch on Sunday, when she would likely be relaxed and when Ella would likely be taking a nap.

This case illustrates several important features of behavior therapy, namely that: (a) the focus of therapy is on *specific problems* as opposed to,

for instance, broad changes in personality or self-concept; (b) *thorough assessment* of problems and their contexts is required for each client; (c) therapists help clients primarily by facilitating changes in overt behavior; and (d) behavior-change recommendations are planned in collaboration with clients. Another feature perhaps not as evident from Robert’s case is that behavior therapists try to help clients develop behaviors that can be beneficial beyond the situation for which they were originally designed. Ideally, once Robert learned to be appropriately assertive with his mother about Ella, he should have a better chance of using assertiveness skills with other people, in other situations, with regard to other topics.

In Review Behavior Therapy

Technique	**Description**
Aversion conditioning and punishment	An aversive stimulus (e.g., mild electric shock) is associated with a stimulus (e.g., alcohol) that currently produces a pleasurable but problematic response (e.g., drunkenness). A problematic response, such as drinking, is immediately followed by a shock or other unpleasant stimulus.
Behavioral activation and activity scheduling	Clients examine what factors influence their mood and then plan activities that provide more environmental reinforcement, and increase their experiences of pleasure and mastery.
Biofeedback	Clients are provided direct feedback about their recorded physiological responses (e.g., heart rate, blood pressure, muscle tension) to help them learn how to regulate these responses.
Contingency management	Operant conditioning principles are used to promote adaptive behavior by rewarding desirable actions—or, less frequently, punishing undesirable ones. The delivery of reward (or punishment) is contingent on the client's behavior.

Exposure	As clients are exposed to situations that distress them or they would normally avoid, the anxiety associated with those situations gradually extinguishes as they learn their feared outcomes do not occur and they gain a sense of mastery.
Habit reversal	Habit reversal techniques are used to treat repetitive disorders, such as trichotillomania (hair-pulling), and involve recognizing an urge or early sign of the problem behavior, and replacing that behavior with a more benign alternative behavior.
Progressive relaxation training	Clients learn to lower arousal and reduce stress by tensing and releasing specific muscle groups.
Response costs	A punishment contingency involving the loss of a reward or privilege following some undesirable behavior.
Shaping and graded task assignments	When behaviors to be learned are complex, clinicians break those behaviors down into simpler steps that can be successfully accomplished, gradually building toward the final complex goal.
Social skills training	Clients with social skills deficits are trained in specific behaviors, such as having conversations, dating, eating at a restaurant, and assertiveness.
Token economies	Clients are reinforced with tokens that act as

	currency to purchase desired rewards (e.g., snacks, television time) when they perform designated behaviors.

Test Yourself

1. In behavioral activation, clients plan activities that will provide ________ from the environment, and increase their experiences of ________ and ________.

2. A fear ________ is a series of increasingly difficult steps designed to reduce ________ behavior and test feared outcomes.

3. A behavioral technique designed to help clients clearly express their feelings and wishes is called ___________, a type of _______________.

You can find the answers in the Answer Key at the end of the book.

Cognitive Therapy

Section Preview Cognitive therapy is built on the assumption that the way we think about situations and process information about them can have a dramatic influence on our feelings, behaviors and relationships. First developed for treating depression, cognitive therapy has grown and been applied to many disorders and has extensive research support for its effectiveness. A key concept in cognitive therapy is that we can treat our thoughts as hypotheses to be evaluated for their usefulness and reasonableness, rather than as facts, and can work toward shifting our thinking and considering new perspectives when our thinking is not helpful. Cognitive therapists work with clients to help identify and re-evaluate unhelpful thinking patterns.

All therapeutic interventions involve thought processes, but **cognitive therapies** are specifically directed toward identifying, evaluating, and changing clients' maladaptive cognitions. These cognitions may include a client's beliefs, attributions, interpretations, images, expectations, schemas, self-statements, and problem-solving strategies.

Cognitive therapy

A treatment approach that aims at identifying, evaluating, and changing clients' maladaptive cognitions.

Theoretical Foundations

We have discussed how behavior therapists originally tended to focus primarily on modifying a client's overt behaviors and/or the environmental situations in which those behaviors occur. By the 1970s, however, many behaviorally oriented theorists had begun to stress the importance of cognitions and "self-statements" as mediators between environmental events and behaviors (Bandura, 1977; Beck, 1976; Ellis, 1973; Meichenbaum, 1977; Mischel, 1973). At around the same time, cognitive theorists in other areas of psychology were making significant contributions to our understanding of human memory, judgment, attention, problem-solving, and social interactions. It became clear that an understanding of psychological functioning that did not include cognitions was incomplete.

As described in Chapter 2, Aaron Beck and Albert Ellis advanced many of the key ideas in cognitive therapy. These include the notions that: (a) in addition to events themselves, our interpretations of events have a big impact on how we feel; (b) our interpretations can vary in how accurate and helpful they are; (c) we tend to develop patterns or cognitive styles, such that we exhibit a bias in our thinking across many situations (e.g., focusing only on negative aspects of situations or judging situations in extreme, either–or terms); and (d) these negative cognitive styles can be activated so readily that they are called *automatic thoughts*, and they contribute to a variety of negative emotions and problematic behaviors.

Cognitive therapists see a small set of *core beliefs* as underlying the negative automatic thoughts that arise in many situations. For example, as Rachel's mother Lena became more depressed, she found herself thinking in

self-critical ways many times throughout the day. When she forgot to pack the twins' lunches before school, she thought, "I'm a bad mother," and when she felt impatient with the slow pace of her husband's search for a job, she thought, "I should be a more patient wife," and, at work, when a bandage she had put on a patient's wound had loosened, she thought, "I'm not a good nurse." The common theme in all these cognitive reactions is that Lena labels herself in extreme, negative ways following even minor events. A cognitive therapist would help Lena identify this thinking pattern and explore the possibility that these negative thoughts arise frequently because they are driven by an underlying core belief, such as "I am inadequate."

Cognitive Mediation. Perhaps the most basic notion in cognitive therapy is that normal and abnormal behavior is routinely triggered by our appraisals, attributions, or interpretation of events, not just the events themselves. *Appraisals* refer to the judgments we make, *attributions* refer to the causal explanations we assign, and *interpretations* reflect the meanings we assign when there is some ambiguity about what is occurring. By virtue of being human, we are constantly assigning meaning in situations and creating a narrative based on incomplete information. For example, we routinely make judgments about other people and what they think about us, even though we do not know what they are thinking. This process is adaptive in that it allows us to function in a world with an overwhelming amount of information which we cannot fully assimilate, but it can also have negative consequences when we develop rigid biases in our thinking styles, routinely assigning negative meanings in situations.

Imagine receiving an invitation to a party where you know there will be lots of strangers. What is your interpretation of this event? There is no way to know in advance exactly how the party will unfold and what the people there

will think of you, so in the face of this uncertainty you will assign some kind of meaning to the situation in order to decide how those people will feel and how they will want to behave. If you tell yourself "Great. I'll be able to meet some new people," your emotional response is likely to be positive (anticipation, excitement), and your behavioral response will be to accept the invitation. But if your interpretation is "I'll probably feel awkward and won't know what to say," your emotional response is likely to be negative (e.g., dread, anxiety), and your behavioral response might be to make up an excuse not to attend. In other words, the same event can produce drastically different reactions depending on what thoughts intervene (see Figure 9.1).

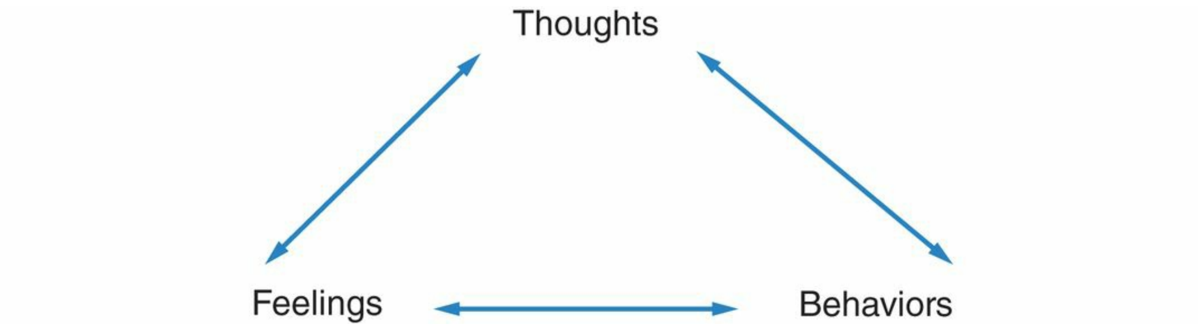

Figure 9.1 The Cognitive Triangle
This diagram illustrates how thoughts, feelings, and behaviors are constantly interacting and influencing each other.

Schemas. With many possible mediating thoughts available to us, what determines which ones we use? According to cognitive psychologists, our thoughts are guided by our **schemas**, also called *schemata*, which are the organized knowledge structures or associations in memory that influence how we anticipate, perceive, interpret, and recall information. For instance, the first time a child goes to the library, she may not know how to understand the event except at a very basic level (e.g., "mom takes me somewhere that has

books”). However, after a few trips, the child will have constructed a fairly detailed understanding that involves knowledge of the setting and of the normal sequences of events and actions that take place there (returning books, finding new books, checking out books, and so on). In effect, the child has internalized a detailed set of beliefs and expectations about how things happen—a “library” schema. Schemas can be built around actions, objects, people, and situations, and can be helpful guides in everyday life. They tell us that movie theaters will be dark, that weapons can hurt people, and that you can buy toothpaste at the supermarket. They can also create problems, as when schemas lead to inaccurate stereotypes about particular categories of people or things.

Schemas
Organized knowledge that influences how we anticipate, perceive, interpret, and recall information.

The schemas that guide our reactions to the world are closely aligned with the core beliefs we described earlier, and can be thought of as the lens through which we process information. While the concept of a schema is somewhat fuzzy and difficult to measure, schemas are of particular interest to cognitive therapists because these filtering lenses so strongly influence how clients perceive themselves and their relations to the world. For example, a depressed person who always feels unworthy is likely to interpret new information in ways consistent with that “unworthy” schema. So, if someone

mentions she is going to lunch and follows it with, “Would you like to come along?” the depressed person is likely to think, “She only asked because she feels sorry for me or because she feels obligated—she really doesn’t want to have lunch with me.” People who are guided by such schemas are typically aware of the negative emotions they feel, but may not be fully aware of having engaged in negative schema-based thinking that led to that emotion. Even when they are aware, they may find it difficult to control the thinking pattern. Why should this be?

Role of Automatic Thoughts. The cognitive approach strongly emphasizes the habitual nature of some thoughts, including many maladaptive thoughts. Negative schema-driven thoughts can be activated so quickly that we may not be consciously aware of having them or of their influence on us, and we often find it difficult to control them. In this respect, the cognitive approach to therapy overlaps somewhat with the psychodynamic approach: Both propose that important mental events can take place without the client’s conscious awareness. For cognitive therapists, however, these nonconscious cognitions are not deeply buried, nor are they made inaccessible by defense mechanisms. Instead, cognitive therapists view our maladaptive cognitions as learned habits that can often become accessible by introspection and questioning. Accordingly, they use the term *automatic* rather than *unconscious* to describe clients’ maladaptive and self-defeating cognitions. The term *automatic* also does a better job of reflecting research evidence that shows that the negative thinking in emotional disorders involving anxiety and depression, for example, is typically involuntary and not easy to control. In other words, this kind of thinking is *unintentional* (it is not preceded by a goal) and relatively *uncontrollable* (hard to modify or stop once it has begun; Teachman et al., 2012).

The list of automatic, often self-defeating cognitions that characterize psychological problems is potentially endless. Table 9.5 presents some of the most common examples of thinking that are often referred to as *cognitive distortions* or *cognitive biases*. Most people are prone to biases in their thinking at various times, but identifying automatic thoughts is valuable in cognitive therapy not because it highlights thinking that is "wrong" or "stupid," but because identifying these thoughts can provide helpful clues for finding new and more adaptive ways of understanding situations.

Table 9.5 Categories of Cognitive Distortions and Sample Automatic Thoughts

Cognitive Distortion Category	Examples of Automatic Thoughts
Dichotomous (all-or-none) thinking	If I can't be famous, I'll be a total failure.
Overgeneralization	He unfriended me—that shows that no one likes me.
Catastrophizing	They didn't hire me—I'll never get a decent job and I'll never be happy.
Personalization	Everyone thinks it's my fault that we lost.
Selective Abstraction (magnification, minimization, disqualifying the positive)	I got one "needs improvement" and 10 "goods" in that evaluation—I'm failing.
Jumping to conclusions	When she said, "some people are

	just clueless," she was referring to me.
Mind reading	He hated my presentation.
Fortune-telling error	I know I'm going to blow the test next week.
Emotional reasoning	I feel guilty—I must be a bad person. I'm scared of airplanes—it must be dangerous to fly.
Unrealistic expectations	Everyone should like me.
"Should" and "must" statements	I should act happy all the time.
Labeling	I'm a loser. She's an idiot.

As cognitively oriented clinicians worked on identifying clients' automatic thoughts, they noticed that people with certain disorders were inclined to employ certain cognitive distortions more than others. For instance, depressed people have a habitual way of explaining the causes of events, particularly negative events. This is called a *negative attributional style*. As suggested by theories in social and personality psychology (e.g., Heider, 1958; Weiner, 1974), depressed people appear to explain negative events in a way that is most damaging to their self-esteem and sense of hope (Abramson, Seligman, & Teasdale, 1978). So, as shown in Table 9.6 when a negative event occurs, depressed people are more likely than nondepressed people to attribute the cause of the event to factors that are internal to

themselves, stable (i.e., something relatively permanent about themselves), and global (something with widespread effects). This negative attributional style is theorized to help create depression and contribute to its maintenance.

Table 9.6 Attributional Tendencies of Depressed People

Event	Internal, Stable, Global (Maladaptive) Attributions Characteristic of Depressed People	Examples of More Adaptive Attributions Characteristic of Nondepressed People
I was home all weekend and no one called me.	It's because of me, it's because I'm not likable, I never will be likable, and this will affect all my relationships.	People are busy right before the holidays (external attribution). I often work on weekends, and my friends know this; that's why they didn't call (unstable attribution, that is, permanent). I have a few close friends, so clearly some people like me (specific attribution).
I got a bad grade on my math test.	I'm dumb and no good at things.	The test was unfairly difficult (external attribution). I didn't study much for this test (unstable attribution). I'm not so hot in math, but I'm good in other subjects (specific attribution).

The idea that characteristic clusters of cognitive biases are associated with specific disorders is called the *cognitive specificity hypothesis*. This hypothesis can help clinicians to conceptualize and assess disorders, develop specific treatment methods, and explain elements of the treatment to clients (Reinecke & Freeman, 2003). However, cognitive therapists recognize that every client is different; the cognitive biases operating in a particular client do not depend entirely upon that client's diagnosed disorder. In fact, as mentioned in Chapter 2, the latest approaches to psychopathology emphasize the role of *transdiagnostic* mechanisms that underlie dysfunction across multiple problem areas (e.g., Amlung et al., 2019; Payne et al., 2014).

Assessment in Cognitive Therapy. Assessment in cognitive therapy is similar to that in behavior therapy, but cognitive therapists are particularly interested in developing a detailed understanding of the triggers, associated emotions and behaviors, and characteristic beliefs and assumptions that underlie the client's automatic thoughts. Accordingly, like behavior therapists, they are likely to measure these behaviors at the beginning of therapy and throughout the course of treatment using rating scales, self-monitoring forms, and standardized instruments. For example, the Brief Fear of Negative Evaluation scale (Leary, 1983) is used in cases of social anxiety disorder to assess negative thoughts about being judged by others.

Role of the Therapist. In some ways, the cognitive therapist behaves like a compassionate, empathic scientist who tries to help clients (a) identify and evaluate the utility of the thoughts they hold about themselves and their experiences; and (b) consider whether alternate more balanced thoughts might be more helpful. The therapist's success in doing so depends in part on having a supportive, productive, and collaborative therapeutic alliance. To foster this alliance, cognitive therapists make it clear that they recognize the

distress associated with the client's emotional experiences, but also that the client has an important role to play in treatment. So in addition to support and trust, the alliance is built on *education* about how self-defeating beliefs, negative attributional styles, and other important cognitive factors can create and maintain psychological disorders (Newman, 2013). This information is important because it helps clients to better understand the therapist's view of their problems, the techniques that will be used to address the problems, and expectations about the client's role in facilitating the process.

Once there is a strong therapist–client alliance and a shared understanding of the rationale for the basic cognitive model, cognitive therapists engage clients in active examination of the client's beliefs and assumptions, focusing especially on the client's negative emotional experiences and associated cognitive distortions. This process is called *collaborative empiricism* because the therapist and client collaborate to assess problems, determine goals, test hypotheses, develop tasks, and measure progress (Wright et al., 2010). It is a process of joint discovery about how thinking patterns may be contributing to problems and what new ways of thinking might be helpful; it is not a process in which the therapist points out "incorrect" thinking. As we already mentioned, clients are often unaware of the beliefs, assumptions, and automatic thoughts underlying some of their problems, so cognitive therapists use some of the interviewing techniques described in Chapter 4 to help them identify those cognitions. In particular, as described below, cognitive therapists often use Socratic questioning and *thought records*, as well as role-playing, a variety of written exercises, self-monitoring, and various other forms of homework.

Goals of Cognitive Therapy

As implied by the theory underlying cognitive therapy, the cognitive therapist's goals in treatment are to: (a) educate clients about the role of maladaptive thinking in determining emotions, behaviors, and a range of relationship and other experiences; (b) help clients learn to recognize when they engage in unhelpful thinking; and (c) teach them skills to re-evaluate their maladaptive thoughts and generate more adaptive ones. Cognitive therapists approach these tasks based on their *cognitive conceptualization* about how a person's thinking patterns influence the client's functioning at different levels.

However, cognitive therapists are not trying to eliminate all negative emotions or sad thoughts—after all, upsetting events occur all the time and it would be inane and insulting to suggest that someone who, say, had a death in the family, should not have negative thoughts and feelings at that time. Cognitive therapists focus instead on trying to identify thoughts that are in some way biased or unhelpful (e.g., those that reflect a cognitive distortion), which may be making situations harder for clients to manage and which maintain distress.

For instance, feeling distress after receiving a poor grade on a test is a natural response; it is when a person thinks to herself "I'm an idiot, I'm never going to graduate" that we see an extra layer of unhelpful thinking that will likely maintain the distress and interfere with addressing the problem (e.g., studying in a different way for the next test). Similarly, many individuals with anxiety disorders engage in self-critical thoughts about the experience of anxiety, which add to their distress. So, when feeling anxious about making a

presentation in class, instead of recognizing that public speaking anxiety is common, a person prone to emotional disorders may think, “I shouldn’t feel this way, I’m so weak.” This example of a *secondary appraisal*, in which people judge their initial reaction to a situation as being unacceptable (Lazarus, 1991; Scherer, Shorr, & Johnstone, 2001), is yet another kind of thought that can make situations and reactions more distressing and difficult to manage.

Cognitive Therapy Methods

The unhelpful patterns of thinking described by cognitive theorists become targets for **cognitive restructuring**, the process of generating more balanced and helpful alternative ways of thinking. This and other therapeutic processes first appeared in Aaron "Tim" Beck's *cognitive therapy* and Albert Ellis's *rational-emotive behavior therapy.* The methods they pioneered strongly influenced today's cognitive and cognitive behavioral approaches to treatment.

Cognitive restructuring
The process of generating more balanced and helpful alternative ways of thinking.

Beck's Cognitive Therapy. Beginning in the 1960s, Beck developed an approach to the treatment of depression based on the assumption that depression and other emotions are determined in part by the ways people think about their experiences (A. T. Beck, 1963, 1972). He argued that depressive symptoms result from cognitive biases and distortions that clients make about the events in their lives (see Table 9.5). For example, they may draw conclusions about themselves on the basis of insufficient or irrelevant information, as when a woman believes she is worthless because she was not invited to a party. They may exaggerate the importance of trivial events, as when a man decides that his vintage record collection is ruined because one

record has a scratch on it. And they often minimize the significance of positive events, as when a student believes that a good test score was the result of luck, not intelligence or hard work.

Aaron “Tim” Beck (1921–)
A founder of cognitive therapy, Beck has published numerous books on cognitive therapy, trained many clinicians in cognitive techniques, and developed several widely used assessment scales, including the Beck Depression Inventory.

(Source: Leif Skoogfors/Corbis Historical /Getty Images.)

Beck (1976) proposed that depressed individuals show a characteristic pattern of negative perceptions and conclusions about three things: themselves, their world, and their future. Attention to this *cognitive triad*, is central to the application of cognitive therapy to depression, anxiety disorders, personality disorders, substance use disorders, and several other problems (J. S. Beck, 2011; Miller et al., 2006). As described in Chapter 7, there is extensive evidence for the efficacy of cognitive therapy.

In the late 1990s, Beck (along with many others; e.g., McNally, 1995) extended his views on automatic thoughts to include perspectives on the role

of automaticity that are more clearly grounded in cognitive science. For instance, his *schema-based model* of anxious processing proposes the activation of a relatively automatic, reflexive "primal threat mode," followed by the activation of a more strategic, elaborative form of cognitive processing (Beck & Clark, 1997). In other words, when we are anxious, there is a bias toward rapidly identifying and attending to potentially threatening information. This bias often operates outside our conscious control, and it is only by directing attention to it through *strategic deliberation* that we can re-evaluate our automatic threat response.

Information processing models, including those that emphasize biases in automatic associations, attention, interpretation and memory for disorder-relevant cues have had a major influence on clinical scientists' understanding of the cognitive factors that maintain emotional disorders (Teachman et al., 2012; Teachman et al., 2019) and on efforts to create *cognitive bias modification (CBM*) methods (Hallion & Ruscio, 2011; MacLeod & Mathews, 2012; Menne-Lothmann et al., 2014; see Chapter 10).

Ellis's REBT. As described in Chapter 2, Albert Ellis proposed a form of cognitive therapy known as **rational-emotive behavior therapy**, or **REBT** (Ellis, 1995, 2001). It was based on the following core principles:

> *When a highly charged emotional Consequence (C) follows a significant Activating Event (A), A may seem to but actually does not cause C. Instead, emotional Consequences are largely created by B—the individual's Belief System. When, therefore, an undesirable Consequence occurs, such as severe anxiety, this can usually be quickly traced to the person's irrational Beliefs, and when these Beliefs are*

effectively Disputed (at point D), by challenging them rationally, the disturbed Consequences disappear and eventually cease to reoccur.

(p. 167)

Rational-emotive behavior therapy (REBT)
An approach to cognitive therapy that directly attacks irrational beliefs that support psychological problems and teaches more rational ways of thinking.

In short, REBT employs a more confrontational approach to cognitive therapy, proposing that psychological problems result from the irrational ideas people hold, which lead them to insist that their wishes must be met in order for them to be happy. The therapist's task in REBT is to attack these irrational, unrealistic, self-defeating beliefs and to instruct clients in more rational or logical thinking patterns that will not upset them (Ellis, 1962; Ellis & Dryden, 1987). The REBT therapist is active, challenging, demonstrative, and sometimes abrasive. Ellis advocated the use of strong, direct communication to persuade clients to give up the irrational ideas with which they indoctrinate themselves into misery. In part because of concerns about this confrontational style, Ellis' approach to therapy is practiced less often today than the more collaborative style proposed by Beck and his followers.

Let's now consider several techniques that come specifically from the cognitive approach to psychotherapy, recognizing that these are often combined with the behavioral approaches described earlier and delivered as

the integrated treatment package known as *cognitive behavior therapy,* described later.

Psychoeducation. Early in therapy, the cognitive therapist begins educating the client about the role of cognitions in disorders. The goal is not to overwhelm the client with information, so if your "teacher schema" calls to mind someone delivering a long, boring lecture, perhaps try invoking your "independent study project mentor" schema. Cognitive therapists try to help clients develop a way of thinking about their disorder that makes it easier for them to collaborate with the therapist and eventually become self-sufficient at identifying, evaluating, and modifying unhelpful thinking patterns. In addition to discussion, the therapist might use diagrams such as the "cognitive triangle" shown in Figure 9.1, recommend videos or books, or assign homework. This kind of "socialization" into treatment is important in all forms of therapy, but it can be especially crucial in cognitive therapy, because if clinicians do not thoroughly explain its rationale, they risk being perceived by their clients as argumentative or insufficiently supportive, and clients are less likely to comply with therapy recommendations (Reinecke & Freeman, 2003). The following example provided by Tim Beck's daughter, Judith Beck (2011), shows how a therapist might use a client's experience to begin educating the client about automatic thoughts.

THERAPIST: [moving to the first agenda topic]. Should we talk about how upset you were at the park yesterday?

CLIENT: Yes.

T: How were you feeling emotionally: Sad? Anxious? Angry?

C: Sad.

T: What was going through your mind?

C: [further describing the situation instead of relating her automatic thoughts] I was looking at the people in the park, hanging out, playing frisbee, things like that.

T: What was going through your mind when you saw them?

C: I'll never be like them.

T: Okay. [providing psychoeducation] You just identified what we call an automatic thought. Everyone has them. They are thoughts that just seem to pop into our heads. We're not deliberately trying to think about them; that's why we call them automatic. Most of the time, they're very quick and we're much more aware of the emotion—in this case sadness—than we are of the thoughts. Lots of times the thoughts are distorted in some way. But we react *as if* they're true.

C: Hmmm.

T: What we'll do is teach you to identify your automatic thoughts and then evaluate them to see just how accurate [and helpful] they are. For example, in a minute we'll evaluate the thought, "I'll never be like them."

The therapist goes on to ask how the client might feel if she had a different thought at the park to make it explicit that changing thoughts can, in turn, change emotions and behaviors. For instance, imagine if the client "restructured" her automatic thought, noting that, "It's hard for me to have a lot of fun right now because of my depression, but it won't always be this way and I can still enjoy parts of being here." Now the client would be

acknowledging the impact of the depression but in a way that allows for hope that things will change, and she has generated a less rigid and more balanced thought that recognizes that some enjoyment is possible. This revised way of thinking can be expected to reduce her sadness and increase her hopefulness.

Re-Evaluating and Replacing Maladaptive Thoughts. The list of cognitive distortions listed in Table 9.5 presents a challenge for the cognitive therapist because, even though these patterns are self-defeating and worsen the client's mood, it is often difficult to shift away from thinking patterns that are deeply engrained through years of practice. Indeed, like everyone else, clients tend to preserve their core beliefs, even in the face of evidence against them. As described in Chapter 3, this pervasive human tendency, called *confirmation bias*, can even create bias in psychologists' clinical judgments. When it comes to core beliefs, we all tend to pay closer attention to evidence that supports our beliefs than to evidence that undermines them.

To help clients overcome this tendency, cognitive therapists ask them to repeatedly practice re-evaluating the value of thoughts, images, assumptions, and beliefs that are tied to negative mood, and then to restructure the maladaptive cognitions. Thus, depressed clients whose negative attributional style leads them to interpret events in the most discouraging way possible are pushed to consider alternate attributions. Anxious individuals who tend to assign threatening meanings to ambiguous events are encouraged to consider more benign alternatives. This includes not only shifting one's initial negative automatic thoughts in response to a difficult situation, but also changing the secondary appraisals that often sustain negative mood. For instance, during the more difficult parts of Lena's struggle with panic disorder, as she thought about going on her own to the grocery store where she had had a panic attack, she probably had the automatic thought "I can't

possibly do this alone," which was followed by the secondary appraisal of her initial reaction, "I'm so pathetic and weak—what grown woman can't do the grocery shopping?!" Re-evaluating both of these thoughts could help Lena be less self-critical and feel more empowered to recognize the possibility that she could handle the challenge of going to the grocery store on her own.

Let's review some of the main techniques that cognitive therapists use to promote cognitive reappraisal and cognitive restructuring.

Socratic Questioning and Guided Discovery. Named after the classical Greek philosopher Socrates, *Socratic questioning* in cognitive therapy is a style of discourse in which the therapist asks questions that help reveal patterns in the client's thinking that are maintaining distress and unhealthy behaviors. The goal is to work together to identify and evaluate automatic thoughts that arise across a range of distressing situations, and determine what beliefs and assumptions underlie the automatic thoughts. Socratic questioning encourages the client to explore whether a given thought makes sense in the situation and whether other ways of thinking might be more helpful and reasonable. Judith Beck refers to this as *guided discovery* and suggests that such questioning helps clients gain distance and see their cognitions as ideas or hypotheses, rather than certainties. Cognitive therapists use Socratic questioning in a way that expresses curiosity, allowing both client and therapist to wonder together about the client's thinking; the therapist does not argue with the client or try to show how the client's thinking is "wrong."

Here are examples of the questions commonly asked by therapists (and eventually by clients) about a client's thoughts (J. S. Beck, 2011, p. 23):

- What is the evidence? What is the evidence on the other side?

- Is there an alternative way of viewing the situation?
- What is the worst that could happen and how could you cope with it if it did happen? What is the best that could happen? What is the most realistic outcome?
- What is the effect of believing the automatic thought? What could be the effect of changing your/my thinking?
- What advice would you give if [a friend or family member] were in the same situation and had the same automatic thought?

Cognitive therapists use a number of variations on these questions, and they also model ways of thinking that provide more balanced, alternative responses. Again, the goal is not for the client to always think "happy thoughts," as this would be unrealistic, but instead to take on the role of a scientist who considers all the evidence to guide thinking. Here is how this approach was used by Dr. Hesse with James Jackson's younger brother, Robert, as he struggled with self-blame about his mother's negative mood. These struggles were especially pronounced when his daughter Ella's behavior was particularly rude and demanding, as this increased the stress level for everyone in the household.

DR. HESSE: What went through your mind when your mother said she was unhappy?

ROBERT: That it was my fault, that I don't do enough to help her, and I expect too much of her with Ella.

DR. H: And what does that thought mean about you?

R: That I should do more, that I'm … lazy … a selfish person. I should take her out more and not criticize how she cares for Ella. It's my fault she's unhappy.

DR. H: I understand that you feel concerned when your mother says she's feeling sad. I see that as a sign you are a caring son. It puts a lot of pressure on you, though, to believe you're responsible for another person's happiness.

R: Well, I don't think I'm the only reason. Her arthritis has been bad lately and she had a fight with her best friend and that has been really upsetting her.

DR. H: That's useful information. What do you think that means for your thought that your mom's sad mood is your fault?

R: I guess there are probably lots of reasons she may be having a hard time, and it's not all about me. But I still want to take her out more and help her feel better.

DR. H: Okay, that seems like an important distinction you're making—that you can help your mom and be part of helping her solve her problems without it meaning that you are lazy or the cause of those problems. How does this different way of thinking affect your own feelings?

R: I feel less sad. It feels good to think I can help my mom without all the guilt.

In this exchange, Dr. Hesse has encouraged the client to consider whether thinking in less rigid and extreme ways can help him manage his distress, and

make choices for his relationships and behavior that feel consistent with his values.

Thought Records. As in behavior therapy, an important component of cognitive therapy is having the client engage in "homework" tasks between therapy sessions. The idea is that "through therapy" clients can learn adaptive skills that become stronger through regular practice. One of the most common homework tasks in cognitive therapy is keeping written records of events that have emotional significance. There are many different forms of these *thought records*, but they all share a focus on providing a structured way for clients to identify their automatic thoughts and associated emotions, and then to generate more balanced alternative thoughts that can be evaluated as to whether they help regulate negative emotions. Clients typically learn this approach in stages, first just working on identifying their automatic thoughts and the intensity of their distress, and noting the types of distortions that the thoughts reflect. Later stages involve the challenging work of re-evaluating and restructuring the thought, and noting whether the more balanced thought reduces distress.

So as Rachel Jackson's dieting became more severe and rigid, her mother, Lena, worried that she was at risk for developing an eating disorder. Rachel's therapist, Dr. Leon, asked Rachel to start keeping thought records to help her identify and evaluate the maladaptive automatic thoughts about eating that have been maintaining the dieting. Table 9.7 shows some of the entries in that record.

Table 9.7 Rachel's Thought Record

Here are a few entries in a thought record completed by Rachel Jackson as she learned to challenge the unhealthy thinking associated with her extreme

dieting.

Situation	Emotions (0–100)	Automatic thought/image	Evidence that supports the thought	Evidence that goes against the thought	Altern balanc thougl
Restricted eating all day, and now fighting the urge to eat pizza, which the family is having for dinner.	Anxious (75) Angry at self (80)	I will be totally disgusting if I eat the pizza. Cognitive distortions: -Dichotomous thinking -Catastrophizing -Emotional reasoning -Labeling	I will feel I've broken my eating rules and be really mad at myself. My tummy often feels bloated after eating pizza.	I haven't eaten much all day and my body needs food. Other people eat pizza and that doesn't make them disgusting. What I eat is not the most important thing about me. My value as a person isn't determined by my	It make nervou eat piz my boc needs f to func and I d want tc make v eat the import thing a me.

diet. I will feel hungry and deprived all night if I don’t eat some food. Calling someone disgusting just because they eat pizza is really harsh.

Continuum Technique. Another cognitive therapy approach is to use a *continuum technique* to help clients recognize that their thinking is extreme and more self-critical than may be warranted. Consider, for example, Lena’s thought that “I’m not a good nurse,” which occurred when she had to re-bandage a wound. She interpreted this event as being her fault for not applying the bandage tightly enough the first time. To help Lena consider whether she was being unduly self-critical in response to this error, a cognitive therapist would encourage Lena to consider where ‘applying a bandage too loosely’ falls along the continuum of potential errors one could make as a nurse (see Figure 9.2).

Minor errors

Serious errors

Arriving at work 5 min late

Applying a bandage loosely

Forgetting to check on a patient

Giving a patient the wrong dose of a medication

Giving the wrong medication to a patient who is allergic to it

Figure 9.2 A Continuum to Evaluate the Seriousness of Errors in Nursing
If Lena and her therapist were to discuss errors that nurses can make, and where on the severity continuum they should be placed, it would become clear to Lena that judging herself so harshly for a loose bandage was not very reasonable.

There is no single, 'right' approach to challenging a given automatic thought, and it is not unusual for therapists and clients to try many different approaches in order to dislodge particularly rigid, firmly held cognitions. So a cognitive therapist working with Lena could also help her to re-evaluate her "I'm not a good nurse" thought using one of the following alternative methods:

1. Identifying the cognitive distortions that the thought likely reflects, which provides useful clues about ways the thought is not reasonable or helpful. In this case, the thought seems to include elements of dichotomous (all-or-none) thinking, overgeneralization, unrealistic thinking, and labeling (see Table 9.5).

2. Socratic questioning could help Lena recognize how unkind she was being to herself. The therapist might ask Lena what she would say to a colleague who had made the same error and engaged in the same self-critical attribution. Lena is unlikely to be as judgmental of her colleague, recognizing instead that everyone occasionally makes errors and this one was relatively minor. This questioning can help Lena recognize the double standard she applies to herself versus others.

3. A thought record could be used to help Lena weigh the evidence for the "I'm not a good nurse" thought and the (likely far more extensive) evidence against that thought. This more balanced perspective would allow Lena to develop a more balanced thought, such as "I want to be more careful when I apply bandages to wounds, but I do good work overall and help many people each day."

A common element in all the possible approaches a therapist and client can take in exploring the client's thinking is evaluating the probability that negative beliefs are actually true, that negative outcomes will actually occur, and what their costs and consequences would be if they did occur. That is, "is the thing I worry about actually likely to come/be true, and if so, could I handle it, and how could I handle it?"

Given that maladaptive, negative thinking is a feature of many forms of psychopathology, especially emotional disorders such as depression and anxiety, it is no wonder that, as described in Chapter 7, hundreds of studies have shown that cognitive therapy has a positive impact on many different disorders, and is particularly noted for its enduring effects in the treatment of depression (DeRubeis, Siegle, & Hollon, 2008).

In Review Cognitive Therapy

Theoretical Concepts	**Definition**
Automatic thoughts	Thoughts or images that come to mind involuntarily and often maintain negative mood or promote unhealthy behaviors.
Core beliefs	Firmly held beliefs (typically about the self) that underlie automatic thoughts in many situations.
Cognitive distortions	Biased patterns of thinking about situations that often perpetuate rigid negative thinking.
Attributional style	A tendency to explain outcomes, especially negative ones, as internally caused, stable, and global.
Schemas	Knowledge structures or associations in memory that guide expectations and how to make sense of information.
Cognitive triangle	Connections between thoughts, feelings, and behaviors; change in one area can lead to changes in the other areas.
Treatment Methods	**Description**
Psychoeducation	The process of socializing the client to the cognitive therapy model and treatment plan.
Socratic	A process in which the therapist asks the client

questioning	questions to explore whether a client's cognitions seem reasonable and helpful.
Thought record	A structured form that guides the client to identify and then re-evaluate automatic thoughts that are associated with distress in order to generate more balanced thoughts.
Cognitive restructuring	The general term ascribed to the process of changing maladaptive thinking.

Test Yourself

1. Instead of arguing with clients, cognitive therapists use ________ questioning and ________ to help clients change unhealthy thinking patterns.

2. Calling oneself an "idiot" is an example of the cognitive distortion called _________.

3. The underlying associations in memory that serve as a script or lens that guide how we view situations reflect our ________.

You can find the answers in the Answer Key at the end of the book.

Cognitive Behavior and Acceptance-Based Therapies

Section Preview Cognitive behavior therapy (CBT) combines the theories and techniques of behavior therapy with those of cognitive therapy. It is a systematic and structured approach that stresses empirically tested methods and has gained wide appeal and shown efficacy in relieving symptoms of many different disorders. Recent extensions of traditional CBT models have also emphasized the importance of acceptance (as well as change), living a life consistent with one's values, and experiencing emotions fully.

Behavioral and cognitive approaches to treatment have combined to such an extent that it is rare to find contemporary books or articles on behavior therapy that do not give serious consideration to cognition, and it is equally rare to find works on cognitive therapy that do not stress behavior change. Conceptual distinctions between the two therapy approaches can still be made, but in practice these are often minimal; they are now better described as **cognitive behavior therapy (CBT)**. In fact, national and international behavior therapy associations have even added "cognitive" to their names (Reinecke & Freeman, 2003). This merger occurred because behaviorally oriented clinicians recognized the importance of cognitions in various disorders, and cognitively oriented clinicians recognized the value of behavior therapy techniques that can help systematically translate cognitive changes into behavioral changes. A large percentage of clinical psychologists currently identify themselves as cognitive behavioral in orientation (Norcross & Karpiak, 2012).

Cognitive behavior therapy (CBT)
Treatment packages for psychological disorders that combine elements of behavior therapy and cognitive therapy.

Further, these two major approaches share an emphasis on the empirical tradition in clinical psychology. Behavioral and cognitive clinicians share a strong belief that they should offer treatment methods that have been shown to be effective in carefully controlled research studies that allow for experimental tests of the causal effects of the treatments (typically the randomized controlled trials we describe in Chapter 7). Given the strong research support for many CBT therapies, these approaches are routinely recommended in clinical practice guidelines (see https://www.guidelines.co.uk/; https://www.apa.org/ptsd-guideline/). This does not mean, however, that CBT therapists assume they should always choose the treatment with the best research support. That's because, consistent with the principles of evidence-based practice, there are cases in which the treatment found to be "best" in a randomized controlled trial may not be a good fit for particular circumstances or a given client's treatment history, personal preferences, or cultural identity. In other words, evidence-based practice suggests that therapists should consult the research literature, but also carefully consider whether a research-recommended treatment might benefit *their* client and monitor outcomes for each client.

Both cognitive and behavioral approaches also emphasize ongoing collection of data during therapy to track therapeutic effectiveness. It is not

enough to just apply a treatment that has strong research support for the *average* person with a given problem and assume it will work for a particular individual; instead, the therapist measures the effectiveness of the treatment for each client (e.g., Brown et al., 2019; Piccirillo & Rodebaugh, 2019). So as in cognitive therapy, the CBT therapist acts much like a scientist, developing hypotheses about how a client's problems fit together and about the key change mechanisms needed to help alleviate those problems, then gathering data to evaluate whether those hypotheses were correct, or whether the therapist and client need to try something new. Notice that this process is similar to the concept of collaborative empiricism described earlier as part of cognitive restructuring.

Both behavioral and cognitive approaches emphasize assessment of the client's current symptoms, functioning, and the contexts in which they occur, and de-emphasize historical factors. For example, CBT therapists do not assume that it is critical to understand the details of childhood attachment relationships to help an adult who is having difficulties in a romantic relationship. Finally, the therapist's role is similar in behavioral and cognitive approaches. Both kinds of therapists strive to be genuine and supportive, and often adopt a coaching stance toward the client—teaching skills, assigning homework, and being directive in setting an agenda for treatment sessions.

Theoretical Foundations and Extensions

The theoretical foundations of CBT are essentially those of the behavioral and cognitive approaches that we have already described. Most who adopt CBT think that the addition of behavioral principles and practices to the cognitive theoretical framework (or vice versa) leads to a clear, persuasive, and evidence-based description of how normal and abnormal behavior develops and can be changed.

There are also some newer, so-called "third-wave" therapies (Hayes & Hofmann, 2017) such as *acceptance and commitment therapy (ACT*; described later) and other approaches that integrate *mindfulness* and highlight the need to work on both change and acceptance. So, whereas some versions of CBT focus on helping clients *change* their thoughts and feelings, acceptance-oriented approaches recognize that we can also reduce distress by observing our experiences, even painful ones, without judging our reactions to them. Think back to Lena's judgment of her anxiety over going to the grocery store and the fact that her distress was worsened when she criticized herself for having that anxiety. An acceptance-based approach would help Lena learn to observe the anxiety she felt about going to the grocery store, and even describe her physical and emotional reactions in detail, but without feeling as though she had to judge or change the anxious reaction. This approach can be especially helpful for problems that cannot be "fixed" in the short term, such as physical pain or grief due to loss of a loved one. Though they are not based on religion, ACT therapies do echo the perspective of the famous "serenity prayer" that has been attributed to Roman Emperor Marcus Aurelius, Saint Francis of Assisi, and most recently to Reinhold Niebuhr, an

American minister of the 1930s: “God grant me the serenity to accept the things I cannot change; courage to change the things I can; and wisdom to know the difference.”

In short, recent forms of CBT tend to integrate concepts from a range of traditions, emphasizing not only change and acceptance, but also the need to pursue one’s values, and to ensure an explicit focus on emotional experience and relationships. This may surprise you if you have heard that the CBT approach is cold, and overly focused on logic rather than feelings. That description applies only when CBT is done badly! In the sections below, you will see that the true focus of the CBT family of approaches is on fully experiencing emotions and learning how to express and respond to them in adaptive ways.

Clinical Applications

CBT lends itself well to a phase approach in which different problems and treatment methods are focused on at different times (Woody et al., 2002). The initial phase begins with assessment. Like behavior therapists and cognitive therapists, CBT clinicians sometimes use formal, standardized tests, especially if they are required to assign diagnoses, but their therapy-related assessments typically entail behavioral rating scales, questionnaires, and client self-assessments.

The therapist and client next review the range of difficulties the client is experiencing—many clients have more than one—and consider how those problems fit together and what common cognitive mechanisms might be driving them. Then, rather than tackling the potentially overwhelming task of addressing everything at once, the client and therapist begin by working on one problem, or one small set of related problems. They typically choose the most serious or disabling problems, or the problems most likely to respond to treatment, or an area that is likely to lead to multiple improvements in functioning or symptom relief.

Specific examples of CBT strategies in the first few sessions of therapy include identifying mood shifts, spotting automatic thoughts, completing thought records, identifying cognitive distortions, scheduling activities, and conducting behavioral activation. There is an emphasis, too, on demonstrating and teaching the basic cognitive model. Over time, treatment sessions focus more on restructuring automatic thoughts, conducting graded exposure to feared stimuli, and starting to work on changing schemas or core beliefs.

During the middle phase of CBT, the therapist and client continue to use their original assessment instruments to track the client's progress. Data from those instruments help them decide whether to keep working on a particular problem (with the same or a different approach), or shift to a new treatment focus. This approach allows therapists to select the research-based treatment that works best for the disorder or problem area being addressed at the moment, while retaining the flexibility to tailor the entire treatment plan to each client's individual needs (Christon et al., 2015; Persons & Hong, 2016).

In the final phase of CBT, sessions usually focus more closely on modifying core beliefs and completing more intense exposure protocols. The therapist encourages the client to do more and more of this work independently so as to eventually "become the therapist." Indeed, because CBT is typically intended to last for months rather than years, one of the therapist's main goals is to help clients recognize the successful cognitive and behavioral strategies they have learned, internalize those strategies, and practice applying them in an ever-widening range of situations. These final sessions also include setting goals for addressing remaining challenges or vulnerabilities, planning *relapse prevention strategies* that will help in high-risk situations that previously triggered symptoms, and preparing for the positive, though often bittersweet, process of ending the treatment program.

Each of the treatment sessions within this three-phase framework tend to be quite structured. In a typical session, the therapist and client briefly review the major events or changes in mood that occurred in the client's life during the past week and then go on to: (a) review their overall goals and treatment strategies, as well as last week's homework progress; (b) identify specific problems and thoughts to be addressed with CBT procedures during the session; (c) summarize the session's progress and its key take-home points;

and (d) decide on homework assignments to be completed by the next session. At the end of each session, the therapist asks if the client felt understood and has any questions or concerns. This final step helps maintain the therapeutic alliance by confirming the client’s status as an active partner in therapy and correcting any potential misunderstandings.

Integrating Cognitive Behavior and Acceptance-Based Therapies

CBT appeared as part of an ongoing evolution in behaviorally oriented clinical interventions. The "first wave" (behavior therapy) focused on observable behaviors and environmental events, and the "second wave" added cognitions to the mix. Not long after behavioral and cognitive therapies became integrated in CBT, there came a "third wave" of methods that emphasizes attention to and acceptance of emotional experiences, and clients' personal values.

These emphases, along with a focus on moment-to-moment experience, mean that third-wave treatments share some important assumptions with the humanistic, existential, and psychodynamic approaches described in Chapter 8. They extend the traditional CBT model by seeking to help clients accept and fully experience emotions rather than to engage in *experiential avoidance* (Hayes et al., 2013). A key element of third-wave treatments is **mindfulness**, the close observation and acceptance of one's current experience without judging it. This element is seen, for example, in *mindfulness-based stress reduction* (e.g., Goldin & Gross, 2010) and *mindfulness-based cognitive therapy* (Segal, Teasdale, & Williams, 2004; Segal et al., 2020), which are now being used widely in the treatment of many disorders (Chiesa & Serretti, 2011; Gu et al., 2015; Hofmann et al., 2010), as well as in efforts to prevent relapse after successful treatment of depression. The mindfulness framework and its associated family of treatment techniques are derived from various religious and secular traditions, with a rich history in Eastern traditions going back thousands of years, including Buddhist and Hindu philosophies. Central to mindfulness approaches is learning to enhance control of one's attention

by selecting a focus, such as one's breathing or other bodily sensations or even an external object and practicing gently redirecting attention back to the selected focus as one's mind inevitably wanders. This approach encourages paying attention to one's present experience, and close observation and acceptance of that experience without judging it, even when the experience may include negative, even painful, emotions.

Mindfulness
An important element of third-wave treatments that encourages observation and acceptance of one's current experience.

Acceptance and Commitment Therapy (ACT). Several "third-wave" treatments have resulted from the integration of mindfulness and acceptance strategies with more traditional cognitive behavior therapy methods. One of the most popular of these is **acceptance and commitment therapy (ACT)**. Its goal is to enhance *psychological flexibility*, the ability to engage fully in the present moment and respond to the situation at hand in a way that is consistent with one's values (Hayes, Strosahl, & Wilson, 2011). The emphasis on personal values helps clients make more fulfilling choices and commit more fully to either behavior change or acceptance, depending on the situation.

Acceptance and commitment therapy (ACT)

A treatment whose goal is to help clients engage fully in the present and respond to situations in ways that are consistent with their values.

ACT therapists work with clients to identify their primary values and assist them in making changes that allow them to think and act in ways that are more consistent with those values. As mentioned earlier, these efforts are similar in some ways to those seen in humanistic therapies. In fact, James Jackson's client-centered therapist, Dr. Alison Goldberg, employed certain elements of ACT to help him to identify his most important values in relation to work, leisure, relationships, and personal growth and health. For example, she asked him to complete the *Bull's-eye* exercise shown in Figure 9.3, which allowed him to see how well his behavior in these areas reflects his values. At the beginning of therapy James felt he was far from the target in most domains of his life. This exercise can help identify important targets for therapy, and repeating it as therapy progresses can serve as a key measure of how effective that therapy is in helping clients live lives that are more fully consistent with their values.

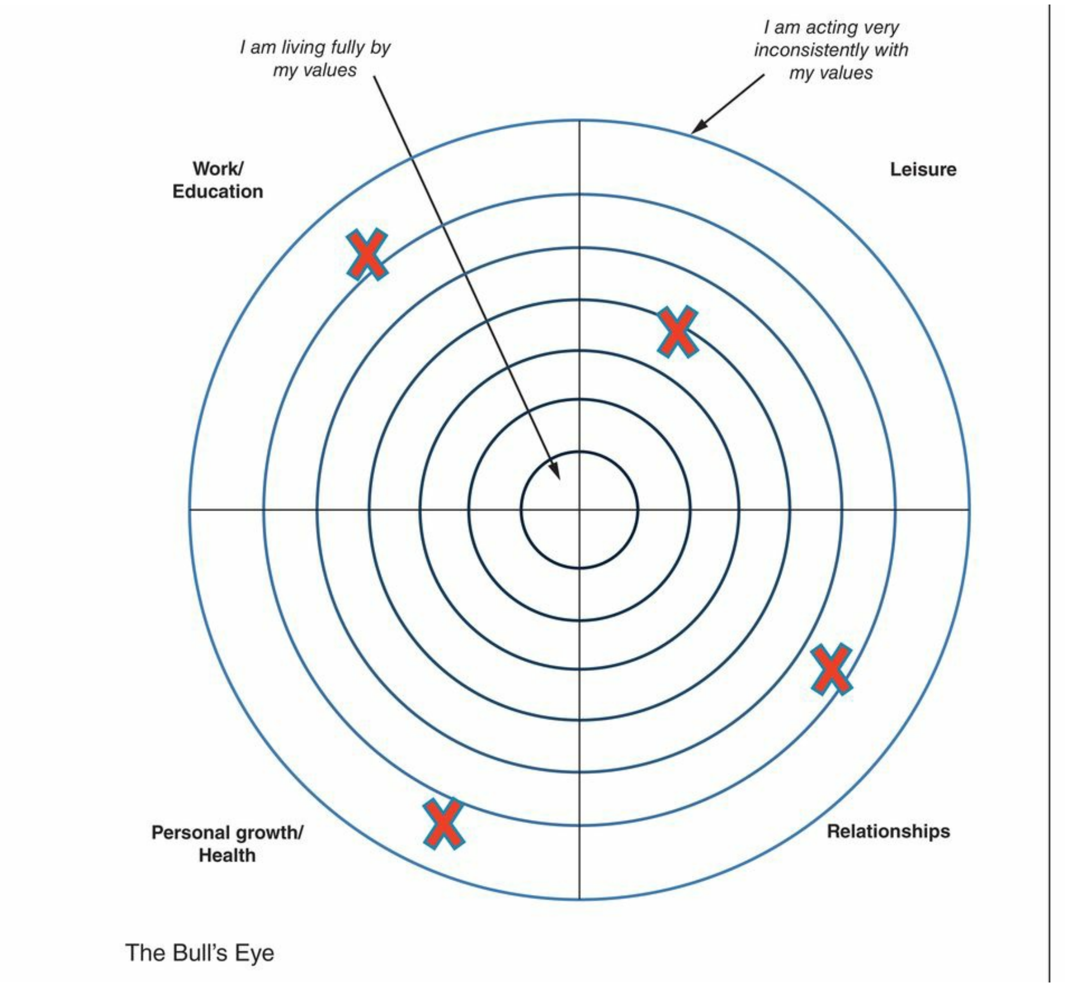

Figure 9.3 James Jackson's Responses to the Bull's-Eye Exercise
The marks that James made on this diagram show that his failure to look for work did not reflect his valuing dedication in the work domain, that his drinking when stressed was inconsistent with his valuing resilience in the personal growth/health domain, and that his ongoing conflict with Lena, Rachel, and his other children conflicted with his valuing of harmonious relationships.

ACT also includes strategies designed to help clients gain some distance from their thoughts (and the words they use to describe those thoughts) that may be perpetuating their problems. For example, *cognitive defusion* and *decentering* help clients recognize that thoughts can be observed without

being seen as central to the self or inherently meaningful. These techniques may involve seemingly small interventions. A therapist may use “decentering” language (e.g., “you had the thought that…” instead of “you believe”), or may ask clients to observe their thoughts without reacting to them, much as if they were clouds drifting by in the sky. The goal here is to help clients recognize that *they* are distinct from their thoughts and how they typically describe those thoughts. While the research base for ACT is not yet as well established as it is for earlier forms of CBT, there is growing evidence that ACT can be helpful for many problems, including anxiety disorders and depression (e.g., Roemer & Orsillo, 2014; Twohig & Levin, 2017), and alcohol use disorder (Byrne et al., 2019).

The Unified Protocol. Some CBT clinicians are applying a transdiagnostic treatment approach called the **Unified Protocol** to a range of emotional disorders, including various anxiety and depressive disorders (Payne et al., 2014). Instead of targeting one disorder at a time, this approach seeks to deal with several disorders at once—not through several different treatments—but with one treatment aimed at eliminating the common underlying mechanisms that are maintaining all the problems.

Unified protocol
A CBT approach aimed at treating several disorders at once by addressing the common mechanisms maintaining all of them.

After an initial phase, which focuses on psychoeducation and increasing clients' motivation for treatment, the therapist uses elements of mindfulness and functional analysis to help clients become more aware of their emotions and to non-judgmentally observe how their thoughts, feelings, and behaviors interact. Next, the clients learn cognitive reappraisal strategies to increase their cognitive flexibility, and work on reducing the behaviors that had led them to avoid or minimize emotional experiences. Then they engage in exposure experiences to actively elicit emotions, because a central goal of the Unified Protocol is to help clients learn to tolerate negative emotions. As with other CBT approaches, the relapse prevention strategies described earlier are used to consolidate treatment gains and avoid the return of problems.

The Unified Protocol is among the newest CBT approaches, so its research base is still being established, but early results suggest that the approach can help multiple emotional disorders just as effectively as single-disorder protocols (Sakiris & Berle, 2019; Steele et al., 2018). If additional empirical evidence replicates the early findings, the Unified Protocol may provide a more efficient approach to treating disorders such as anxiety and depression by focusing on the key principles of change needed to address the dysregulated emotions involved in these disorders.

Dialectical Behavior Therapy (DBT). Pioneered by Marsha Linehan (Koerner & Linehan, 2011; Linehan, 1993), **Dialectical Behavior Therapy (DBT)** provides another important example of the integration of cognitive behavior and acceptance-based approaches. It is being used successfully with traditionally treatment-resistant populations, including clients who display the impulsive behavior, mood swings, fragile self-image, and stormy interpersonal relationships associated with borderline personality disorder (see Neacsiu & Linehan, 2014). Many of these clients are adolescents or

young adults who display multiple disorders, and many have heightened risk of suicide or self-harm. DBT is also being applied in areas beyond borderline personality disorder, such as bulimia nervosa (Chen & Safer, 2010; Safer, Telch, & Agras, 2001).

Dialectical behavior therapy (DBT)
An integrated cognitive behavior and acceptance-based approach being used with borderline personality disorder and other treatment-resistant problems.

Given the scope of problems faced by clients with borderline personality disorder and other pervasive difficulties, it should not be surprising that DBT is often a multifaceted treatment that lasts considerably longer than more traditional forms of behavior therapy and CBT. Initially, DBT helps clients develop skills to manage their harmful and therapy-interfering behaviors, and then helps them confront any prior traumatic experiences—such as physical or sexual abuse—that might have contributed to their current emotional difficulties. This phase of treatment concentrates on eliminating self-blame for these traumas, and emphasizes the importance of building a life worth living.

By consistently helping clients see that almost all events can be thought about from varying perspectives, the dialectical behavior therapist tries to encourage clients to see the world in a more integrated or balanced way (Van Dijk, 2013). For instance, the DBT *wise mind* reflects the integration of logic

and emotion, recognizing that both have value in guiding our responses and decision-making. Similarly, DBT emphasizes the importance of validating the client's experience and at the same time challenging the client to develop skill at both accepting and changing unhelpful thoughts and behaviors. Skill-building falls into four main areas: increasing mindfulness, learning emotion regulation strategies, becoming more interpersonally effective, and learning distress tolerance.

Research on the use of DBT for adult borderline personality disorders has shown it to be effective in reducing suicidal and self-harm behaviors when compared with treatment as usual (Cristea et al., 2017; DeCou, Comtois, & Landes, 2019). Other studies have found significant pre- to posttreatment reductions in self-harm behavior in adolescents (Ougrin et al., 2015). More research is needed to determine the effectiveness of DBT compared to other treatments for reducing depressive symptoms and treatment dropout in cases of borderline personality disorder, but the value of DBT for reducing suicidality cannot be overemphasized, making it a very important addition to the cognitive behavior and acceptance-based family of approaches.

The examples of cognitive behavioral and acceptance-based interventions cited here are by no means exhaustive, but they illustrate the broad range of problems and populations to which they can be applied and some of the features they share. These shared features include a fundamental assumption that thoughts need not be treated as facts that hold power. The treatments help clients realize that we all have a choice: our thoughts can be observed closely, made more distant, endorsed, or modified, depending on the situation and how the thought aligns with our values and goals. In addition, these interventions are based on the shared belief that emotions

need not be avoided, and that even when fear or other uncomfortable or painful emotions arise, one can choose to experience them fully and adopt behaviors that fit one’s personal values and goals.

The Current Status of Cognitive Behavior and Acceptance-Based Therapies

CBT and related third-wave approaches have surged in popularity in the past 25 years. Articles and books on CBT have proliferated, and an increasing number of clinical psychologists identify themselves as taking a cognitive behavioral approach (Hollon & DiGuiseppe, 2011; Wade, 2012). The popularity of CBT approaches seems due in part to their straightforward, problem-oriented approach. Most of them are designed around specific problem behaviors or cognitions, and so the translation from symptom to treatment is relatively clear. Further, the steps to be taken in treatment are usually described in specific terms and in organized sequences, sometimes in highly structured procedure manuals. Compared to other approaches, especially psychodynamic and humanistic approaches, the structure of cognitive behavior therapy makes it easier for trainees and practicing clinicians to learn. At the same time, with hundreds of manual-based treatments available, it has become impossible to learn them all in detail. As a result, clinical scientists are increasingly embracing transdiagnostic approaches like the unified protocol that develop effective treatments from principle-based methods to address multiple problem areas (Barlow et al., 2017; Farchione et al., 2012; Gros, 2019; Harris & Norton, 2019).

Fortunately, because the cognitive behavioral approaches all share a firm commitment to empirical evidence, the benefits of older and newer approaches will continue to be subjected to scientific tests (Baardseth et al., 2013). So far, the results of those tests are generally quite positive. Indeed, another important reason for the popularity and evolution of CBT is the

unusually strong empirical research base that supports its efficacy. There are now so many meta-analyses examining CBT's effects, that researchers can conduct reviews of the meta-analyses. One such review identified more than 250 meta-analyses of CBT that covered an astonishing range of problem areas and client types, including children, adolescents, and young, middle-aged, and older adults (Hofmann et al., 2012). The problems for which the efficacy of CBT has the most robust research support include anxiety and somatoform disorders, as well as bulimia, stress, and anger management problems (e.g., van Dis et al., 2019).

These results do not mean that CBT works for every problem and every client. There is still room for improvement in CBT outcomes in many areas, and there is still a need for more studies with better controls and greater rigor to increase confidence in findings. There is also a crucial need for more randomized controlled trials of CBT with more diverse populations. For example, we don't yet fully understand how well CBT works with racial and ethnic minority clients and those at low income levels. Further, while the results of third-wave therapies like ACT and DBT are promising, evaluation of their outcomes across different populations and settings are still in the early stages and there is still a need for studies that use more rigorous research methodologies (Öst, 2008). Nevertheless, clinical scientists are making exciting progress along all these lines of research, including in determining how CBT works and how the basic science of learning can help enhance its effects (Bruijniks et al., 2019; Ewbank et al., 2020; Zieve et al., 2019).

For more information on cognitive behavioral and related approaches to therapy, we recommend that you consult one of several excellent textbooks on the subject (J. S. Beck, 2011; Craske, 2017; Dobson, 2012; Leahy, 2017;

Ledley, Marx, & Heimberg, 2018; Newman, 2013; Van Dijk, 2013; Wright, Sudak, Turkington, & Thase, 2010).

In Review Cognitive Behavior and Acceptance-Based Therapies

Treatments	Main Features
Cognitive behavior therapies (CBTs, including the Unified Protocol)	Based on the principles of learning and on research from cognitive, developmental, and social psychology, CBT helps clients evaluate the function of different thoughts, feelings, and behaviors, and modify responses that maintain problems.
Acceptance and Commitment Therapy (ACT)	Combines mindfulness and acceptance strategies with more traditional behavior-change strategies to increase clients' ability to engage in the present moment, and behave in ways that are consistent with their values.
Dialectical Behavior Therapy (DBT)	Helps clients develop skills to manage unhelpful behavior; emphasizes the importance of building a life worth living through mindfulness, emotion regulation strategies, learning distress tolerance, and other skills.
Target for Change	**Treatment Methods**
Cognitive (thoughts)	Socratic questioning, thought records, continuum technique, identifying core beliefs, perspective-taking, etc. to help clients identify and evaluate unhelpful thought patterns, and consider whether

	alternate patterns would be more helpful.
Behavioral (actions)	Exposure techniques, behavioral activation and activity scheduling, problem-solving, social skills and assertiveness training, contingency management and habit reversal, biofeedback, and, less frequently, aversion therapy and punishment.
Acceptance and values	Mindfulness breathing, attentional control exercises, thought defusion, Bull’s-eye exercise, identifying primary values, observing without judging, acceptance of situations, even unpleasant ones.

Test Yourself

1. Cognitive, behavioral, and acceptance-based approaches all emphasize the importance of _________ research to guide treatment planning and evaluation.

2. In the evolution of behavioral approaches to treatment, cognitive behavior therapy would be considered to be in the ______ wave.

3. One of the most important elements in third-wave behavioral therapies is a concept known as _________________.

You can find the answers in the Answer Key at the end of the book.

Chapter Summary

Behavioral and cognitive behavioral therapies are based on the principles of learning and on basic research from experimental psychopathology, cognitive, developmental, and social psychology. Their treatment methods are aimed at evaluating the function of various thoughts, feelings, and behaviors, their fit to the person's environment, and at modifying those responses that maintain maladaptive behaviors and distress. Behavioral methods include various kinds of exposure techniques, behavioral activation and activity scheduling, problem-solving, social skills and assertiveness training, contingency management and habit reversal, biofeedback, and, less frequently, aversion therapy and punishment, among many other methods.

Cognitive therapy methods were pioneered by Beck's cognitive therapy for depression and Ellis's rational-emotive behavior therapy. These methods, and those that followed, stressed the mediating role of cognitions in behavior, especially the influence of maladaptive cognitions that reflect rigid, biased patterns of thinking (e.g., either–or thinking, overgeneralization, and catastrophizing). The cognitive therapist's primary task is to help the client to identify and evaluate these cognitive patterns and adopt more helpful alternate ways of thinking. The treatment process makes use of Socratic questioning and many other techniques. As in behavior therapy, homework assignments also play a role—clients in cognitive therapy are often asked to keep a record of their automatic thoughts and associated emotions and behaviors. As they practice using cognitive therapy techniques, clients

become adept at more balanced ways of thinking about and responding to various kinds of life situations.

Cognitive behavior therapy and its recent extensions combine elements of behavior therapy, cognitive therapy, and acceptance-based and values-focused approaches whose theoretical and procedural approaches are often highly compatible. This compatibility provides cognitive behavior therapists with a wide array of interventions. Cognitive behavior therapists stress empirical research, preferring interventions that have been validated by controlled studies. Currently, a large percentage of clinical psychologists identify themselves as cognitive behavior therapists (Norcross & Karpiak, 2012).

10

Delivering Mental Health Services

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Contents

Dissemination and Implementation of Clinical Interventions

Group Therapy

Couples and Family Therapy

Alternatives to In-Person Therapy by Mental Health Professionals

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Chapter Preview

This chapter provides an overview of dissemination and implementation science, which focuses on how clinical interventions can be effectively implemented with various client populations in various settings. We review some of the ways—other than the one-to-one in-person format—that mental health care can be delivered, including in groups, couples, and families. We also describe some exciting advances in technology-delivered services, the increasing role of non-specialist providers in delivering mental health care around the world, and community-based efforts to prevent the onset of mental health problems. We conclude the chapter with a discussion of self-help and complementary/alternative medicine approaches to treatment, highlighting the broad range of methods available to deliver mental health services and the need to consider a wider range of delivery models to help reduce the worldwide gap between treatment needs and treatment availability.

It is estimated that nearly half the people in the United States will experience a mental disorder at some point during their lifetime (Kessler et al., 2007, 2009). These disorders have enormous costs to individuals and to society in the form of impairments in relationships, physical health, and academic and occupational performance, not to mention increased risk of suicide. There are economic costs, too. Expenditures for mental disorders in the United States for just 1 year (2012) were more than 80 billion dollars (Soni, 2015). Yet the majority of people who are struggling with a mental disorder do not receive care, a situation known as the **treatment gap** (Kohn et al., 2004). The same problems exist worldwide. Surveys by the World Health Organization (Kessler et

al., 2004) in 14 countries across several continents have found that the proportion of those receiving mental health care for their psychological or substance use disorders ranges from a low of 0.8% in Nigeria to a “high” of only 15.3% in the United States. Given the scope of the treatment gap, it has become clear that continuing to rely mainly on highly trained mental health professionals to offer one-to-one in-person therapy will never substantially reduce the worldwide burden of mental illness (Kazdin & Blase, 2011). As a result, there is now growing interest in **dissemination and implementation science**, which seeks ways to distribute evidence-based clinical interventions more effectively, sustainably, and widely, and in forms that allow the interventions to be integrated in clinical practice by mental health professionals, and trained nonprofessionals, often aided by the use of technology.

Treatment gap

The disparity between the number of people who need mental health services and the availability of and access to those services.

Dissemination and implementation science

A field aimed at finding ways to more effectively, sustainably, and widely distribute evidence-based interventions in forms that will be integrated and applied in different settings.

Dissemination and Implementation of Clinical Interventions

Section Preview In this section we describe categories of psychological interventions other than one-to-one treatment, and consider the challenges of using these interventions effectively on a large scale.

The growth of dissemination and implementation science and the introduction of new models of care are based on the idea that whether people receive and benefit from mental health services depends partly on *how* those services are delivered, not just on *what* the services offer. Consider an evidence-based treatment for depression, such as CBT. It could be offered by two or three doctoral-level psychologists at a community mental health clinic (where the wait for treatment is likely to be many months), but as we describe later in this chapter, it could also be delivered by trained non-specialist sub-doctoral or nonprofessional providers working in schools, private rooms at hair salons, and pharmacies (e.g., Linnan, D'Angelo, & Harrington, 2014). A digitized version could even be delivered via the internet to anyone with a computer or mobile phone without requiring the presence of a human counselor.

In fact, one-to-one treatment by mental health professionals is just one of five general categories of interventions that can help people with mental disorders (Kazdin, 2018, p. 7-8). The others include:

1. *Informal interventions*: These are not systematic but are the ones that many people employ in their everyday lives, such as seeking contact with friends,

family, and pets, as well as exercising, self-medicating (e.g., using alcohol to ‘unwind’), or taking a vacation.

2. *Formalized, not mental health-specific interventions*: These are not tied to recognized mental health professions, but are implemented in systematic ways, such as in yoga sessions or religious affiliation and practices.

3. *Complementary and alternative interventions*: These include a broad range of approaches that often have origins outside the traditional Western medical model, such as dietary supplements, acupuncture, and massage.

4. *Population-based interventions*: These often draw on policy, regulations, and laws to influence behavior, such as increasing taxes on cigarettes to encourage people to quit smoking.

As innovations in clinical care delivery models continue to expand, these four categories continue to grow such that the distinctions among them and the lines between them and traditional one-to-one professional treatment are often blurred.

The Challenges of Dissemination and Implementation

The processes involved in trying to more broadly and systematically disseminate any kind of evidence-based clinical treatment are complex and require multiple steps to ensure implementation. Imagine, for instance, that the director of the mental health clinic where Lena Jackson consulted with Dr. Cynthia Leon about her daughter Rachel's behavior problems was approached by a group of researchers who suggested that all the clinic's therapists should start using a new evidence-based method for treating panic disorder. Even if the director is convinced that this is a good idea, the change would not be easy to implement because many or most of those clinicians may not know how to administer the new intervention, may not want to change how they typically practice, or may already be so busy that investing the time needed to make the switch feels like a big hassle that might not be worth the effort.

If the researchers are to be successful in disseminating and implementing the new treatment, the clinic administrators and clinicians would first need to be educated about the added value of the new treatment compared to the older ones. Further, some or all of the clinicians would need to be paid for the training required to become competent with the new treatment, and the clinic would have to develop a system for ensuring that all clinicians are delivering the same treatment according to similar empirically supported procedures and that they are not "drifting" from those established protocols over time (Waller & Turner, 2016). At the same time, the clinic administrators would need to consider whether the new treatment will fit (or will need to be adapted) to match the cultural background of the clients in

their setting. Finally, to help justify the time, effort, and expense involved, the administrators would want to evaluate the new treatment's impact, with a special focus on whether clients are now improving more quickly and more completely than had previously been the case.

Given complexities such as these, it is easy to see why clinical scientists often struggle to disseminate and implement treatments, even those that have strong empirical research support. One notable exception is the United Kingdom's massive Improving Access to Psychological Therapies (IAPT) program (Clark, 2018). For decades, the UK's National Institute for Health and Care Excellence (NICE) has provided practice guidelines to inform health-care professionals about what treatments have strong research support for various disorders (www.nice.org.uk/). However, after psychologist David Clark and economist Lord Richard Layard calculated the enormous cost savings that would accrue if these high-quality treatments were provided on a large scale to people with disorders such as depression and anxiety, the British government approved the IAPT program. So far, it has trained more than 10,000 clinicians to deliver empirically supported treatments and to evaluate the outcomes. This national program is shaping the treatment of nearly 1 million clients each year.

Some features of the IAPT program reflect a set of more general characteristics associated with effective treatment dissemination (Kazdin, 2018), including being:

1. Scalable enough to permit delivery to large numbers of people;

2. Able to reach people who are often not adequately served by traditional models;

3. Affordable compared to traditional models;

4. Expandable to a nonprofessional workforce so that more people can offer the services;

5. Capable of providing services in settings (such as pharmacies or grocery stores) where people already go;

6. Capable of being implemented and adapted as needed to fit local conditions;

7. Flexible enough to allow multiple delivery options;

8. Acceptable to clients and clinicians.

You can learn more about the growing field of dissemination and implementation science in the *Users' Guide To Dissemination and Implementation in Health for Researchers and Practitioners* (http://www.crispebooks.org/DisseminationImplementation/workbook-20PE-253VC.html). Also, for an excellent discussion of the treatment gap and the need for alternate delivery models, see Alan Kazdin's (2018), *Innovations In Psychosocial Interventions and Their Delivery: Leveraging Cutting-Edge Science to Improve the World's Mental Health.*

New Models for Delivering Therapy

As described in Chapter 2, during the early 20th century psychotherapy was dominated by Freud's psychodynamic model, which was designed for treating individual clients in person. The behavioral and humanistic approaches that emerged during the mid-20th century were also originally designed for individual treatment formats.

Since that time, however, a number of treatments have evolved in which therapy is offered to more than one client at a time and in which the focus is on relationships or relationship systems, not individuals (see Table 10.1). Group therapy was the first of these socially oriented therapies, followed somewhat later by the advent of couples and family therapy.

Table 10.1 Socially Oriented Therapies

Intervention Mode	Emphasis
Group therapy	Understand and alleviate disturbances tied to interpersonal relationships, mental disorders, or problems in living (e.g., academic stress) in a group setting.
Couples therapy	Help couples in intimate relationships to improve problem-solving and communication skills.
Family therapy	Change harmful family interaction patterns so that the family system functions better.

These modes of intervention reflect trends in psychology that view individuals' behavior, whether disordered or not, as a reflection of the

relationship systems they inhabit. The move toward group therapies also reflected the treatment gap mentioned earlier, and the consequent need to increase the efficiency of mental health service delivery. After all, if eight people can be treated in a group using the same amount of clinician time and resources that it would take to treat an individual client, the impact of that clinician’s services can be greatly increased.

The availability of multiple treatment formats is important, too, because it allows clinicians to choose what may be an optimal delivery model for a given client based on factors such as the nature of the problem, the resources available, the fit to that setting or population, and which model has been most strongly supported by empirical research.

In Review Dissemination and Implementation of Clinical Interventions

Concept	**Description**
Treatment gap	The difference between the number of people needing mental health services and those actually receiving care.
Dissemination	The process of effectively distributing mental health-care information, assessment, and intervention materials to a particular public health or clinical audience.
Implementation	The use of targeted strategies to promote the adoption and integration of research-supported mental health assessments and interventions into various clinical and community settings.

Test Yourself

1. To address the treatment gap, we need to consider both _____ services are being offered and _____ those services are being offered.

2. Beyond in-person therapy, what other categories of interventions can help people with mental disorders?

3. Expanding the reach of mental health services will require expanding the number of _____________ and offering services in ___________ where people already go.

You can find the answers in the Answer Key at the end of the book.

Group Therapy

Section Preview In this section we offer an overview of group therapies and discuss their inner workings. In addition to covering traditional supportive and process-oriented groups, we focus on cognitive behavioral group therapy and psychoeducational groups.

Group therapy was first practiced at the turn of the 20th century in Boston by physician Joseph Pratt with some of his tuberculosis patients. The increased use of group therapy was later stimulated by the shortage of professional personnel around the time of World War II (Burlingame & Baldwin, 2011). Its popularity continued to grow, especially during the 1960s and 1970s, and the group treatment format is now regarded as a valuable intervention in its own right (Burlingame, MacKenzie, & Strauss, 2004).

Group therapy

The treatment of several unrelated clients at the same time—often, the clients have a similar problem area.

Every major approach to clinical psychology offers group therapy. There are analytic groups, client-centered and Gestalt groups, and cognitive and behavioral groups, among many others. This is because, to varying degrees, clinicians across therapeutic traditions recognize the importance of interpersonal relationships and realize that many clients' problems involve

difficulties in those relationships. Evidence-based practices are being integrated into group therapy formats, especially in cognitive behavioral groups (Crits-Christoph et al., 2013), but empirical evaluation of group therapy is still lagging behind that of individual delivery models (Carpenter et al., 2018).

Therapeutic Factors in Group Therapy

Group therapies are meant to serve several clients at the same time, with the added benefit of providing support from other group members (Bieling, McCabe, & Antony, 2006). Indeed, group therapy is considered more than the simultaneous treatment of several individuals. Groups provide therapeutic opportunities that cannot be found in individual therapy, and group therapists must learn how to use those opportunities. We summarize these concepts below, and a fuller discussion is contained in standard references on traditional group therapy (e.g., Corey, 2017; Yalom & Leszcz, 2005):

- ***Sharing New Information.*** New information is imparted from two sources in groups: The group leader may offer information, demonstrate skills, or offer advice, and these resources can also come from other members of the group who share their experiences and ideas. Often, feedback from group members can have more impact on clients than feedback from a therapist. This was certainly the case for Rachel Jackson’s father, James. His client-centered therapist, Alison Goldberg, invited him to attend a few sessions of group treatment with clients who, like James, were responding to stress with excessive drinking. James found it helpful to hear other group members describe the methods they were using to help them cope with stress without immediately resorting to alcohol.
- ***Instilling Hope.*** Group members can share their hope for the effectiveness of treatment, including by providing encouraging comments about the positive changes that they see in other members.

- ***Universality.*** By showing that everyone struggles with problems, therapy groups help their members learn that they are not alone in their fears, low moods, or other difficulties. Learning about the universality of one's problems also soothes anxiety about "going crazy" or "losing control."
- ***Altruism.*** Groups give clients a chance to discover that they can help other people, which in turn can increase their feelings of self-worth and strengthen the belief that they too can make positive changes.
- ***Interpersonal Learning.*** A properly conducted therapy group is an ideal setting to learn new interpersonal skills. It presents repeated opportunities to practice those skills with various types of people and with immediate feedback on performance.
- ***Group Cohesiveness.*** Members of cohesive groups accept one another, and are willing to listen to and be influenced by the group. They participate in the group readily, feel secure in it, and are relatively immune to minor disruptions of the group's progress. Cohesive groups also permit the expression of anger or other negative emotions toward group members, provided such conflicts do not violate the norms of the group. Meta-analytic studies suggest that group cohesion is one of the most important factors underlying the beneficial effects of group therapy (Burlingame, McClendon, & Alonso, 2011).

The Practice of Group Therapy

Therapy groups usually consist of 6 to 12 members. Some leaders of traditional groups believe that they should be *homogeneous*, consisting of members who are similar in age, sex, and type of problem. Others prefer to form *heterogeneous* groups that include a mix of clients with different backgrounds and problems. Heterogeneous groups are easier to form and they also have the advantage of exposing members to a wider range of fellow clients. In practice, of course, groups will always be homogeneous on some dimensions (e.g., diagnosis or primary problem area) and heterogeneous on others (e.g., problem duration, personality characteristics, and coping style).

A Therapy Group Meeting

Group therapy sessions can run for the traditional one-hour period, but may last two hours or more because it takes more time for all clients in a group session to share their experiences and to process the information that is presented.

(Source: Klaus Vedfelt/DigitalVision/Getty Images.)

Cognitive Behavioral Group Therapy

Cognitive behavior therapy is one of the more common treatment approaches being used in group formats today (Crits-Christoph et al., 2013); indeed, cognitive behavioral techniques are used five-times more often than other group methods (Burlingame & Baldwin, 2011). Cognitive behavioral groups include psychoeducational components that focus on learning, skill-building, and sharing information, rather than mainly emphasizing the interpersonal group process. In other words, the therapist's primary interest is in addressing the clients' identified diagnosis or problem area, rather than analyzing relationships within the group (see Table 10.2). This approach has been used effectively with many kinds of clients and problems, including depression and anxiety disorders in adults (Goldin et al., 2016; Oei & Browne, 2006), children and adolescents (Wergeland et al., 2014); PTSD in veterans living in remote locations where therapy is provided via video teleconferencing (Greene et al., 2010); alcohol abuse in college students (Michael et al., 2006); problems related to coping with cancer (Schnur & Montgomery, 2010); substance abuse in outpatients (Petry, Weinstock, & Alessi, 2011); grief interventions for children who survived traumas (Salloum & Overstreet, 2008); and chronic insomnia (Koffel, Koffel, & Gehrman, 2015), among many others.

Table 10.2 Sample Treatment Protocol for Cognitive Behavioral Group Treatment

Here is an outline of the cognitive behavioral treatment procedure protocol for the first session of group treatment for clients suffering from a combination of depression and social anxiety disorder. More information on

these procedures and other group therapy approaches is available from several sources (e.g. Corey, 2017; Free, 2007; Wenzel et al., 2012; Yalom & Leszcz, 2005).

Session 1

1. Introduction of therapists and group members

2. Group “rules”

- **a.** Confidentiality
- **b.** Check-in and rating scales
- **c.** Homework
- **d.** Missing appointments

3. Introducing the CBT approach to depression and social anxiety disorder

- **a.** Behavioral interventions: Activation and exposure
- **b.** Cognitive interventions

4. Describing the biopsychosocial model of depression and social anxiety disorder, and introducing the five components:

- **a.** Behavior
- **b.** Thoughts
- **c.** Emotions
- **d.** Biology
- **e.** Environment

5. Overview of social anxiety disorder, including

a. The nature of fear and social anxiety (e.g., occasional social anxiety is normal and has a survival function)

b. Myths and misconceptions regarding fear and social anxiety

c. The three components of fear: feelings (physical & emotional), cognitive, behavioral

6. Homework: Complete biopsychosocial model and purchase companion manual

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Source: Bieling, P. J., McCabe, R. E., & Antony, M. M. (2006). *Cognitive behavioral therapy in groups* (p. 382). New York, NY: Guilford Press. Copyright 2006 by Guilford Press. Adapted with permission.

In Review Group Therapy

<table>
<tr><th>Advantages</th><th>Some Therapeutic Factors in Group Formats</th></tr>
<tr><td>Effective
Affordable
Efficient
Recognizes social context</td><td>Sharing new information.
Instilling hope.
Learning new skills.
Interpersonal learning and practice.
Experience of universality.
Opportunities for altruism.
Group cohesiveness.</td></tr>
<tr><td colspan="2">Test Yourself

1. Group therapy usually involves _______clients, all of whom agree to keep information shared in group meetings _______.

2. Therapy group members are often somewhat ________ in terms of their main problem area, but they can be ________ with respect to their other characteristics.

3. Cognitive behavioral groups typically include ________ components designed to teach clients about research on the nature of their problems and how best to change unhelpful ways of thinking.

You can find the answers in the Answer Key at the end of the book.</td></tr>
</table>

Couples and Family Therapy

Section Preview In addition to treating multiple unrelated clients, group therapy can focus on couples and families. In this section, we review couple and family therapies, which tend to focus on a disturbance within these close relationships, such as conflict between spouses or romantic partners, or between parents and children.

In *couples therapy* and *family therapy*, the focus is on relationship problems rather than just on the individuals who happen to be in those relationships. Couples therapy used to be referred to as *marital therapy*, but the current term is more descriptive because it includes a wider array of heterosexual and same-sex couples, including spouses, cohabitating partners, romantic partners who do not live together, and any other pair of individuals who consider themselves a couple. **Couples therapy** focuses on the dyad rather than the individual partners, while **family therapy** focuses on relationships involving at least two generations, typically including one or more parents (or guardians) and their children. Because both couples and family therapy emphasize communication patterns within close relationships, therapists who work with couples often work with families and vice versa.

Couples therapy
Treatment that focuses on the relationship between partners rather than on the individual partners.

Family therapy
Treatment that focuses on relationships between and among at least two generations of family members.

Prior to the 1950s, few therapists worked with couples or families (Harway, 2005), but since the 1970s, the number of couples and family therapists has increased rapidly (Chabot, 2011). Journals devoted to family psychology first appeared in the United States and Japan during the 1980s, and the Division of Family Psychology was founded within the American Psychological Association in 1985 (Kaslow, 2011). Courses in family psychology are now offered by many graduate programs in clinical psychology, counseling, and social work.

Diagnosis in Couples and Family Therapy

When working with individuals, clinical psychologists typically describe their clients' disorders using the *Diagnostic and Statistical Manual of Mental Disorders* (DSM; or the *International Classification of Diseases*, or ICD), but in couples and family therapy, the client is seen as a *relationship* or *system of relationships*. How should these relationships and systems be understood and diagnosed? Are there identifiable patterns for dysfunctional relationships that might eventually point the way to effective intervention techniques?

The development of diagnostic categories for interpersonal conflicts has begun. The initial work in this area led to *V-Codes* for relational problems in *DSM-IV*. V-Codes are "Other Conditions That May Be a Focus of Clinical Attention" and include, for instance, parent–child relational problem (V61.20), partner relational problem (V61.10), and sibling relational problem (V61.8). Codes could be listed on Axis I in a *DSM-IV* diagnosis, but most insurance companies did not reimburse for V-Codes. Some clinicians suggested that disorders in relationships and relational processes, such as relationship distress or partner and child maltreatment, should become formal diagnostic categories in the *DSM-5* (Beach & Kaslow, 2006). That did not happen (Lawrence, Beach, & Doss, 2013), partly because clinical scientists have not yet adequately established the reliability, validity, and utility of relational diagnoses. Nevertheless, there is a great deal of interest in conducting the research necessary to do this (Lawrence, Beach, & Doss, 2013; Wamboldt, Kaslow, & Reiss, 2015).

Couples Therapy Methods

Couples seek therapy for a variety of reasons, but as shown in Table 10.3, especially because of problems in affection and communication (Doss, Simpson, & Christensen, 2004) that tend to occur more frequently at particular stages of a relationship (see Figure 10.1).

Table 10.3 Reasons Couples Seek Treatment
The problems that bring couples to therapy tend to be the same whether the couple is heterosexual or homosexual (Long & Andrews, 2011).

Reason for Therapy	% of Couples Reporting Problem
Distress (e.g., basic unhappiness, feeling alone)	57
Communication	57
Divorce/separation concerns	46
Improve relationship	46
Arguments/anger	44
Concerns about children	32
Sex/physical affection	28
Spouse critical/demanding	8
Spouse distant/withdrawn	8

Trust issues	8
Social activities/time together	8
Infidelity/flirting	6

Source: Adapted from Doss, B. D., Simpson, L. E., & Christensen, A. (2004). Why do couples seek marital therapy? *Professional Psychology: Research and Practice, 35*, 608–614.

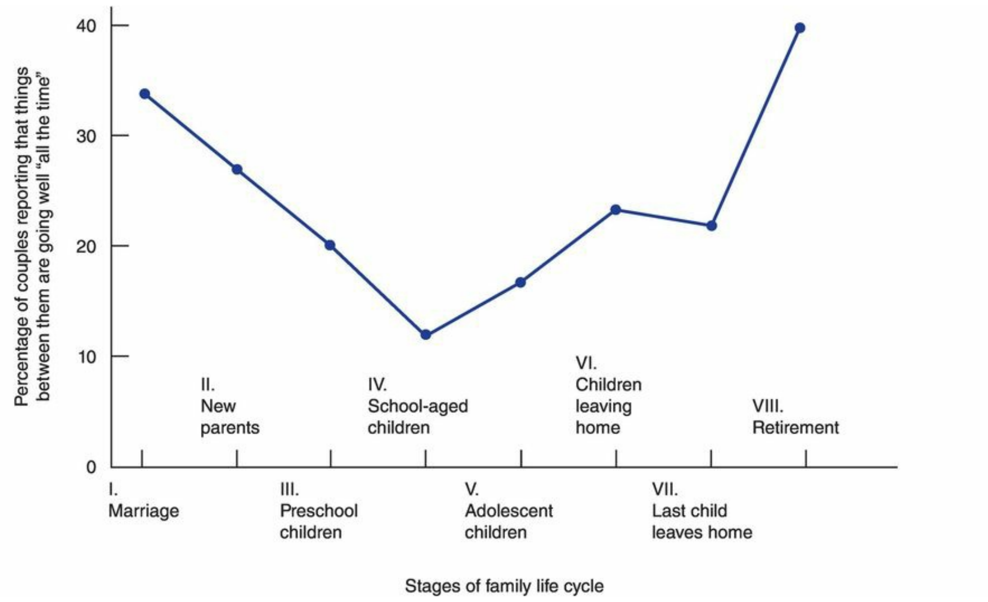

Figure 10.1 Marital Satisfaction over Time
Couples are most likely to seek couples therapy when satisfaction with their relationship is at a low point. This graph illustrates marital satisfaction, but its shape is likely the same for unmarried couples too.

(Source: Boyd, D. & Bee, H. (2015). *Lifespan development* (7th ed.). Upper Saddle River, NJ: Pearson.)

As already mentioned, couples therapy focuses mainly on relationship difficulties, but it can sometimes be combined with methods designed to address other problems. For example, as in the case of James and Lena

Jackson, when depression, alcoholism, or severe anxiety disorders affect the quality of a client's marriage or partnership, those problems might well be tackled through couples therapy—or at least through the involvement of the client's partner (Baucom, Epstein, Kirby, & Falconier, 2011). Indeed, there is growing interest in the idea that the effects of treatment for an individual client's problem, such as obsessive-compulsive disorder, can be enhanced by simultaneously targeting that client's family relationships through couples-based cognitive behavior therapy (Abramowitz et al., 2013).

Whatever the specifics, couples therapists usually see both members of the couple at the same time, a procedure called *conjoint therapy*. In other cases, each partner is seen separately for some or all sessions. This is especially likely in *separation counseling*, when couples ask for help in ending a marriage or long-term relationship with a minimum of conflict over property and/or child custody.

The goals and techniques of couples therapy depend partly on the conflicts that are of greatest concern for each couple and partly on the theoretical orientation of the therapist. For example, therapists who prefer systemic interventions and who see couples as interpersonal systems rather than as two individuals would try to intervene at the level of the system (Weeks & Treat, 2015). Systemic therapists usually assume that there is circularity and interrelatedness in each individual's experience of the couple relationship. For example, the following statements alone could be seen as linear, but together they show the circularity of the couples' relationship from a systemic framework (Weeks & Treat, 2001, p. 28):

THERAPIST TO WIFE: Why do you get so angry?

WIFE: Because he always withdraws from me.

THERAPIST TO HUSBAND: Why do you withdraw?

HUSBAND: Because she is always so angry.

In contrast, a behaviorally oriented couples therapist would likely address a couple's communication problems by teaching the partners to replace hostile, unconstructive criticism with comments that clearly express feelings and directly convey requests for the behaviors that each wants from the other. Cognitive behavioral couples therapists work to help couples change the way they think about their relationship and modify the attributions they make about each other (Fischer, Baucom, & Cohen, 2016). Accordingly, the cognitive behavior therapist may teach each member of the couple to recognize, for example, that the other member's anger may reflect anxiety about the future of the relationship, not necessarily an effort to end it.

Cognitive behavior therapists are not alone in doing this; most couples therapists tend to emphasize problem-solving (Baucom et al., 2011). The touchstone of problem-solving is teaching the couple how to communicate and negotiate more effectively with each other. Among the multiple tasks involved in building better communication are teaching the couple to accept mutual responsibility for working on problems, encouraging perspective-taking, maintaining a focus on current relationship problems rather than old grudges, fostering expression of preferences rather than demands for obedience, and negotiating compromises to problems the couple decide cannot be solved. These goals would clearly be relevant in James and Lena Jackson's relationship because, as we described in Chapter 1, James felt criticized by Lena for not finding a new job and for drinking too much, while Lena felt that James does not appreciate the stress she was experiencing as the family's sole wage earner and the one responsible for running the house

while dealing with the problems of her adolescent daughter and aging mother. Lena tried to help James ‘fix’ his difficulties, but that only made him feel more criticized and inadequate.

Challenging communication dynamics like these often emerge in distressed relationships. Clinicians who employ *integrative behavioral couples therapy* help couples identify the key themes that are challenging for them and then analyze the major factors contributing to that problem, including *d*ifferences in perspectives, *e*motional sensitivities, *e*xternal circumstances, and *p*atterns of interaction. Through this DEEP analysis, the couple begins to recognize how they have ended up feeling stuck in a “mutual trap” from which it seems impossible to escape. The therapist then uses a series of strategies to help the couple change this seemingly hopeless situation. These include communication and problem-solving training, building empathic connections and promoting emotional acceptance.

Regardless of procedures or theoretical orientation, whenever there are two clients in the consulting room, therapists must be careful to avoid becoming *triangulated* by the couple—that is, for example, finding themselves in the middle of the clients’ disagreements. Here are some suggestions for preventing triangulation (Weeks & Treat, 2001):

- Don’t take sides.
- Don’t proceed until the problem(s) and goal(s) have been clarified.
- Don’t discuss problems abstractly and non-concretely.
- Don’t discount problems, even small problems.
- Don’t assume the partners in the couple will perceive the problem in the same way.

- Don’t get hooked in the past.
- Don’t allow the couple to take charge of the session.

Many of these same suggestions apply when therapists work with families.

Family Therapy

As mentioned already, family therapy aims to identify interaction patterns that are supporting disturbed family relationships, and then helps family members change those patterns for the better and thus improve the relationships (Stanton, 2013). Like couples therapy, family therapy arose from recognition that the problems of individual clients occur in interpersonal contexts and have interpersonal consequences. It was observed, for example, that clients who showed great improvement during individual therapy while hospitalized often relapsed when they returned to their families. This observation, along with other clinical insights and research, led to several early theories that emphasized the family environment and parent–child interactions as causes of maladaptive behavior (Bateson et al., 1956; Lidz & Lidz, 1949; Sullivan, 1953). Thankfully, the field has shifted away from theories that blame parents (traditionally, the mother) as the main cause of their children's psychopathology, but it remains important to recognize the role of family relationships as influencing and being influenced by mental health problems.

Family therapy often focuses first on the family member who is seen to have particularly noticeable problems. In the Jackson family, for example, the *identified client* was 17-year-old Rachel, whose falling grades, crash dieting, and other difficulties led her mother, Lena, to seek help for her. As described in Chapter 9, Rachel entered in-person one-to-one cognitive behavior therapy, but her therapist, Dr. Leon, would have likely also recommended some family therapy sessions that included her parents, siblings, and perhaps even her grandmother. In those sessions, she would try to reframe Rachel's

problems in terms of disturbed family processes or maladaptive family communication, to encourage all family members to examine their own contributions to the problems, and to consider the positive changes that each member can make to solve them. As in couples therapy, then, a common goal of family therapy is improved communication and the elimination of coercion in the family system (Chabot, 2011).

As with individual, group, and couples therapy, there is no single agreed-upon technique for conducting family therapy. Rather, therapists can select from a wide variety of techniques. One form of family therapy is known as *parent–child interaction therapy*. Originally developed by Sheila Eyberg (Eyberg & Matarazzo, 1980), this therapy is based on principles from attachment theory. Therapists using this approach work with both parents and children, with a particular focus on coaching parents about how to interact with the children. Parent–child interaction therapy has been found to be very effective with a number of childhood problems, especially oppositional defiant disorder (Funderburk & Eyberg, 2011), depression (Luby, Lenze, & Tillman, 2012), and anxiety disorders (Comer et al., 2012), and has even been effectively delivered over the internet (Comer et al., 2017).

Family therapists who employ a behavioral approach help family members to find new and more productive ways of expressing their needs. They teach parents to be firm and consistent in their child-discipline practices, and encourage each family member to communicate clearly with the others. They also help family members to use behavioral principles such as reinforcement rather than punishment, to stop blaming the identified client for all the family's problems, and to help everyone consider whether their expectations of other members are reasonable. These behavioral methods are

also used in *multisystemic therapy*, which conceptualizes families from a systemic, ecological perspective (Henggeler, 2011).

A Case Example of Family Therapy

Behavioral parent training (Briesmeister & Schaefer, 2007), sometimes called *parent management training* (Kazdin, 2008), has been used to effectively treat a number of externalizing behavior problems in children, such as oppositional defiant disorder and aggression. Behavioral parent training can be modified for use with adolescents, too, as illustrated in the case of Sal, a 13-year-old friend of Rachel Jackson's brother, Jamal.

Sal, like Jamal, is seen by teachers as a "problem kid." He is quick to anger and has been suspended from school a number of times for fighting, stealing, and yelling at teachers. Since he was in preschool, Sal's mother, Maria, has felt that she could not control his behavior, and got no help from Sal's father, who largely ignores the family in favor of watching television and drinking beer. Due to the repeated suspensions from school, Maria finally decided to get help for Sal.

Behavior therapist Dr. Zenia Vasconcellos (not her real name) recommended a treatment program consisting of several components, including anger management and behavioral parent training. One of the key features of that training is to document the child's problematic behavior objectively in order to target behaviors for improvement. Maria told Dr. Vasconcellos that Sal is disrespectful and disobedient, but had difficulty providing more than a couple specific examples of behaviors that bothered her. She also acknowledged that, other than complaining about Sal's behavior, she did little to try to stop him from acting out.

Thus, Dr. Vasconcellos first worked with Maria to identify problematic behaviors and to generate ideas of how to handle those behaviors more

effectively. She suggested that Maria identify just two or three behaviors to start modifying rather than trying to change everything at once (a strategy that often backfires on the family). In choosing behaviors to target for intervention, Dr. Vasconcellos taught Maria to: (a) be specific; (b) begin with problems you can see; (c) start with fairly neutral behaviors; (d) select behaviors that occur at least two or three times per day; and (e) say what replacement behaviors are needed.

Maria chose to target Sal’s disobedience and disrespectful gestures (e.g., smirking, sighing, rolling his eyes). Because using a time-out procedure is not effective with older children, Dr. Vasconcellos worked with Maria to develop a behavioral contract with Sal whereby there were no positive consequences for unwanted behaviors (e.g., he did not get his way when he complained about something) and there were clear positive consequences for desirable behavior. Based on a point chart that was posted in the kitchen, Sal could earn points for adaptive behaviors (e.g., getting up on time, doing his chores, obeying his mother) and he would lose points for maladaptive behaviors (e.g., disobeying or disrespecting his mother). At the end of each day, Sal could cash in his points for things like watching television (if his homework was done), playing a video, and texting and talking on the phone with his friends.

Both Sal and his mother embraced this program, and with relatively little upheaval, Sal’s behavior began to improve. Because his behavior at school was also tied to the point chart at home, behavioral improvements were seen both at school and at home (case adapted from Weisz, 2004). Notice that Sal’s behavior improved even without his father’s participation. His case illustrates that behavioral parent training can be effective with just one parent, but the effects are more long lasting when both parents are

involved (Phares, Fields, & Binitie, 2006). Not all cases show such rapid improvement, especially when the clients are adolescents, but this one shows that behavioral parent training can change both the parent's and the child's behavior (Weisz, 2004).

The Social Contexts of Couples and Family Therapy

Some of the most important challenges for couples and family therapists come from the *social contexts* in which couples and families live (see Figure 10.2). Consider the fact that fewer than half of children under the age of 18 in the United States live in so-called traditional nuclear families with heterosexual parents who are in their first marriage (Livingston, 2014). The rest are configured as multigenerational, multicultural units; foster families; blended families; gay or lesbian couples with children; several people living together with no legal ties but with strong mutual commitments, and other family structures (Kaslow, 2011). To be effective in working with such a wide range of social constellations, therapists must understand the special problems each type of family faces and must guard against the influence of bias against family structures that differ from their own.

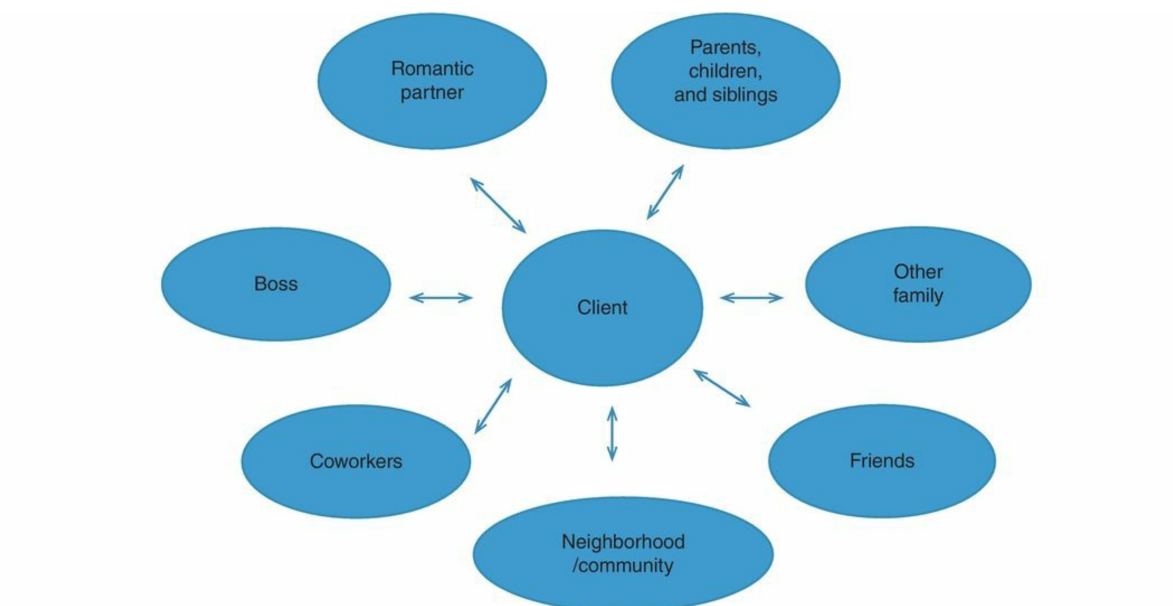

Figure 10.2 The Social Contexts of Families and Couples

> Couples and families are invariably embedded in a larger social network, and their functioning is partly dependent on what is going on in that network at any given time.

Our description of couples and family therapy has been brief. You can find far more information about the options and techniques available in a number of authoritative sources (e.g., Becvar, 2013; Carr, 2012; Doherty & McDaniel, 2009; Gottman, 2011; McGoldrick, Giordano, & Garcia-Preto, 2005; McHale & Lindahl, 2011; Nichols & Davis, 2016; Schulz et al., 2010).

In Review Couples and Family Therapy

Similarities between Couples and Family Therapy	**Differences between Couples and Family Therapy**
Focus on close relationships. Improve problem-solving and communication skills to strengthen relationships. Therapists must be careful not to take sides. All clients must examine their contribution to the problems.	Couples therapy focuses on the dyad rather than larger family system. Family therapy often includes members of more than one generation.

Test Yourself

1. The two main problems that lead couples to seek therapy involve ________and ___________.

2. Therapists who conduct couples or family therapy see the _________ as the client.

3. Parent management training is a feature of __________________approaches to family therapy.

You can find the answers in the Answer Key at the end of the book.

Alternatives to In-Person Therapy by Mental Health Professionals

Section Preview In this section, we review the challenges and the promise associated with mental health service delivery through means other than in-person treatment by mental health professionals. Some of these alternatives, such as herbal medicine and mindfulness methods, are centuries old while others, especially those that apply the latest digital technology, have emerged only in the last few years. We will begin by describing the growing role of technology in treatment, and then consider the role of non-specialist providers in promoting mental health, preventing disorders, and offering community-level interventions. We will also consider the self-help movement, and treatments that involve complementary and alternative medicine.

Our discussion of group, couples, and family therapies has been focused on treatments delivered face-to-face by clinical psychologists and other licensed mental health professionals. However, the same treatment gap that led to the rise of these methods has also fueled a wide range of alternative delivery systems.

Technological Innovations

For example, the advent of ever more sophisticated digital technology has led to an explosion of new mental health service delivery models. These *eHealth (e = electronic) or mHealth (m = mobile) models* include, among others: web-based and app-based interventions delivered via computers, smartphones, and tablets; online informational resources; Facebook and other social media; videoconferencing (e.g., Skype and Zoom); emailing and texting; virtual reality systems; and even gaming systems (e.g., Marshall, Dunstan, & Bartik, 2019; Wasil et al., 2019). Some of these approaches are fully automated and involve no human contact. Other approaches require only limited contact with a professional therapist, or involve nonprofessionals who are trained to serve as coaches or in other roles that do not require an advanced mental health degree. Still others simply use remote contact technology such as video conferencing to allow mental health professionals to deliver relatively traditional clinical assessment and treatment services (Glueckauf et al., 2003, 2018). All of these various approaches can be especially helpful to clients in locations where they would not otherwise have access to mental health services, or who would otherwise face long waits for access to in-person care (López et al., 2018).

Here are just a few examples of the methods and results of using technology to deliver or enhance evidence-based mental health care:

- Versions of cognitive behavior therapy delivered by mental health professionals via the internet (iCBT) have now been tested in hundreds of randomized controlled trials. A recent meta-analysis that included 1418 participants found that both iCBT and face-to-face

treatment produced comparably positive overall effects (Carlbring et al., 2018). There are even studies showing that iCBT delivered in a multimedia, automated way without the use of a therapist can achieve results comparable to those of face-to-face treatment (e.g., Cavanagh et al., 2006; see www.beatingtheblues.co.uk).

- A web-based smoking-cessation program offered in English and Spanish has been visited online by more than 290,000 people in 168 countries (Muñoz et al., 2016).
- In a randomized study of anxiety treatments, children who received a combination of face-to-face and online interventions showed improvement comparable to those who received face-to-face treatment alone (Spence et al., 2006). Similarly, a study of adolescents who were randomly assigned to receive CBT for anxiety either online or in person found that both groups showed comparable gains, which were significantly better than those seen in a no-treatment group (Spence et al., 2011).
- Standardized text messages were sent to low-income adult clients in a CBT program for depression, and were found to help the clients remain more engaged in treatment (Aguilera & Muñoz, 2011).
- Videoconferencing was used in a web-based behavioral parent training program to offer live coaching for parents of children with problems related to traumatic brain injuries (Wade et al., 2011).
- Virtual reality technology was used to create visual environments, such as bars, that were associated with cravings for smoking. These

virtual scenes were then used in cue exposure therapy to help smokers quit (Garcia-Rodriguez et al., 2012; see Chapter 9).

- After being treated for eating disorders, women had access to a web-based package (including peer support, self-help, psychoeducational modules, and access to a therapist). Their treatment gains were better maintained than those of a group that did not get the web-based package (Gulec et al., 2011).

Thinking Scientifically What are the Effects of Trying to Change Cognitive Biases Using Technology?

A class of training programs called *cognitive bias modification (CBM)* is a particularly interesting example of technology-based interventions. Borrowing from the learning theories and cognitive behavior therapy approaches described in Chapter 9, these programs give clients extensive practice at changing a particular problematic style of thinking. For instance, individuals like Rachel Jackson's mother, Lena, who have a history of panic attacks, tend to selectively focus on threat cues and have trouble shifting their attention away from those cues. So Lena would likely find words such as "panic," "faint," and "heart attack" much harder to ignore compared to words like "sunshine," or "paper." If she were to begin treatment with a type of CBM called attention bias modification, she would engage in lots of online practice at shifting her attention away from anxiety- or panic-related cues and thus help change her unhelpful cognitive style—all without seeing a live therapist. Clients with social anxiety

disorder or substance abuse problems might practice shifting their attention away from pictures of scowling faces or liquor bottles.

Other cognitive bias modification programs focus on *interpretation bias,* a tendency to assign negative meanings to ambiguous situations. For Lena, when she notices her heart beating faster, instead of interpreting that ambiguous cue as a sign that she has become a little anxious or been rushing somewhere, she is likely to misinterpret it as the beginning of a heart attack, which would escalate her panic reaction. A common CBM program targeting such interpretation bias would present many different brief written scenarios on a computer screen or mobile phone app that describe emotionally ambiguous but potentially threatening events. The ambiguity in the scenarios is resolved when the individual completes a word fragment at the end of the scenario that establishes its outcome. For instance, a person with social anxiety might read:

> *"You are invited to an anniversary dinner given by your partner's company. You have never met any of your partner's work colleagues and you wonder what they will think of you. As you prepare to leave for the dinner, you think that the new people will find you fr_endly."*

Because the word fragment is easy to complete, it guides the client toward assigning a non-threatening meaning to the scenario. The idea is that with repeated practice across many different scenarios, the anxious person learns not to assume that the outcome of ambiguous situations will be negative and threatening.

What am I being asked to believe?

Advocates of many automated eHealth interventions claim that meaningful symptom reduction can occur without a therapist's involvement. In the case of CBM, the claim is that clients will experience symptom reduction simply by practicing a new thinking style using standardized training materials, without talking specifically about their personal problems. These claims are still being evaluated and there is ongoing debate about how meaningful the effects of CBM can be (see Cristea, Kok, & Cuijpers, 2015; Hallion & Ruscio, 2011; MacLeod & Mathews, 2012; Menne-Lothmann et al., 2014).

What kind of evidence is available to support the claim?

Many studies have provided strong support for CBM, including evidence that interpretation bias training for acrophobia (fear of heights) achieved results equivalent to exposure therapy, which is the gold standard phobia intervention (Steinman & Teachman, 2014). Some meta-analyses of CBM also suggest that the procedure can be helpful, though mainly as a supplement to standard psychotherapies rather than on its own (Menne-Lothmann et al., 2014).

Are there alternative ways to interpret the evidence, including those that my biases and preconceptions might have kept me from seeing?

Another meta-analysis of research outcomes reached a more negative conclusion, namely that "CBM may have small effects on mental health problems, but it is also very well possible that there are no

significant clinically relevant effects" (Cristea et al., 2015). In an effort to make sense of these mixed reports, other reviewers looked at 12 meta-analyses and concluded that CBM did better at reducing symptoms of anxiety than symptoms of depression, but that its only established long-term benefits thus far are for clients with substance abuse problems (Jones & Sharpe, 2017).

What additional evidence would help to evaluate the alternatives? Current research on CBM has tended to use small samples and short follow-up periods, and has not paid enough attention to factors such as client characteristics and treatment conditions (e.g., CBM alone or in combination with therapist contact) that might impair or amplify treatment effects. There is also not enough evidence yet about how CBM works, when it does work. For instance, are the effects based specifically on practicing positive interpretations, or does CBM lead to a more general increase in cognitive flexibility? Thus, we need more large-scale studies of more diverse client samples, using designs that are capable of determining which clients, with which problems, are most likely to be helped by CBM. We have to recognize, too, that the "CBM" label actually reflects a wide range of specific approaches, and that very different outcomes have been used to assess its effectiveness (e.g., change in diagnosis, questionnaire-based symptom reduction, and ratings of subjective distress in the face of a mild stressor in a laboratory setting). In short, many questions remain about how best to measure CBM effects and how its various versions work under what diverse conditions.

What conclusions are most reasonable given the kind of evidence available?

As is true of many other technology-based treatment services, both attention bias modification and interpretation bias modification programs show promise, but they need to be tested further to determine the boundaries of their effects and to find ways of making make them more reliably helpful for more people.

Accordingly, at this point it does not make scientific sense to draw broad conclusions about the overall effectiveness of CBM. It will likely work well under some conditions but not others, and we still need to map out those conditions. At the moment, the benefits of CBM are somewhat in the eye of the beholder. Those who have a positive view of CBM tend to focus on encouraging research results, while skeptics tend to focus on the less encouraging results. It is ironic, but true, that clinicians' own attentional and interpretation biases are likely guiding their evaluations of attention and interpretation bias modification!

Regardless of the final verdict on CBM specifically, the use of technology-based services for most mental health problems will continue to grow (Eonta et al., 2011). They will expand treatment options, but they will not entirely replace human clinicians or face-to-face interventions. So clinicians will always have to deal with some unique ethical problems associated with the delivery of therapy and other services through digital technology (Perle et al., 2013; see Table 15.7 in Chapter 15). Some of these problems relate to maintaining clients' privacy and there are worries that

people may misrepresent themselves online. It can be difficult, for example, to confirm that an adult caregiver has provided consent for a minor to participate in treatment. Further, how will clinicians providing internet-based care intervene when a client appears suicidal or when child abuse is suspected? And who is responsible in such situations when treatment is being delivered without direct human contact?

Still other challenges relate to the explosion of mental health apps and web-based programs, themselves. There is now a huge and confusing online marketplace of services, most of which have not yet been well tested, making it more important than ever for potential clients to do some homework before deciding whether to use them. For example, they can visit PsyberGuide.org, which provides reviews of popular eHealth programs, including information about the extent to which various programs have strong empirical research support. Despite these challenges, most clinical psychologists and other mental health professionals see the benefits of using technology to offer cost-effective, evidence-based services to millions of people around the world who need those services but might not otherwise receive them.

Non-Specialist Providers

The treatment gap that stimulated technology-based treatments has also led mental health experts to consider other creative service delivery models. In one of these, called "task shifting," interventions that would normally be available only from a professional are delivered by specially trained **paraprofessionals**, also known as **non-specialist providers (NSPs)** who are not mental health professionals. Instead, they may be hairdressers, pharmacists, peers, bartenders, and people who fill many other roles in the local community.

Paraprofessionals (non-specialist providers, or NSPs)
Nonprofessionals who are specially trained to deliver mental health interventions.

The idea of training NSPs to offer certain mental health services originated in the 1960s as one aspect of the *community psychology* movement that we will describe later. Task-shifting has the advantage of allowing a far larger number of people to have at least some exposure to the mental health services they might need. Imagine, for instance, that a high school's only professional counselor trains one student in every classroom to provide some basic counseling services, including the active listening skills associated with client-centered therapy (see Chapter 8). Doing so would vastly increase the number of providers available to students who need someone to talk to about

their problems. Training NSPs not only increases the availability of certain services, but may lead more people to use them, partly because the NSPs are *indigenous paraprofessionals,* so-called because they are trusted “locals” drawn from the very groups that will receive their services. Indeed, their cultural rootedness in the to-be-served group is typically one of their fundamental assets (Kohrt et al., 2018).

Providing Psychological Service Where It Is Most Needed
There are now a great many programs around the world through which NSPs offer services in schools, homes, and refugee camps, among many other settings.

(Source: Anadolu Agency/Anadolu/Getty Images.)

NSPs and Global Mental Health. Can an NSP without an advanced degree in mental health effectively deliver evidence-based mental health care? Research has not yet established exactly which client populations and problems require treatment by a specialist with advanced training and which can be helped by NSPs, but there is now impressive evidence that NSPs can achieve good outcomes in low- and middle-income countries when delivering

well-defined treatment elements that draw from established behavioral, interpersonal, emotional, and cognitive therapy approaches. In fact, a recent review of 27 studies, mostly targeting depression or posttraumatic stress, found moderate to strong support for the value of treatments provided by NSPs who had been trained for an average of about 54 hours (Singla et al., 2017; see Figure 10.3). These treatments typically involved no more than 10 sessions. Results like these do not mean that NSPs can take over delivery of all mental health care. For one thing, NSPs typically require a fair bit of supervision in their work, and high-risk clients, such as those with suicidal thoughts or intent, are typically referred to a professional. However, it does appear that many common elements of evidence-based treatments can be disseminated in ways that would greatly expand their reach. This has led many experts to suggest that task-shifting and community-based interventions should be the "foundation of the mental health-care system" (Patel et al., 2018).

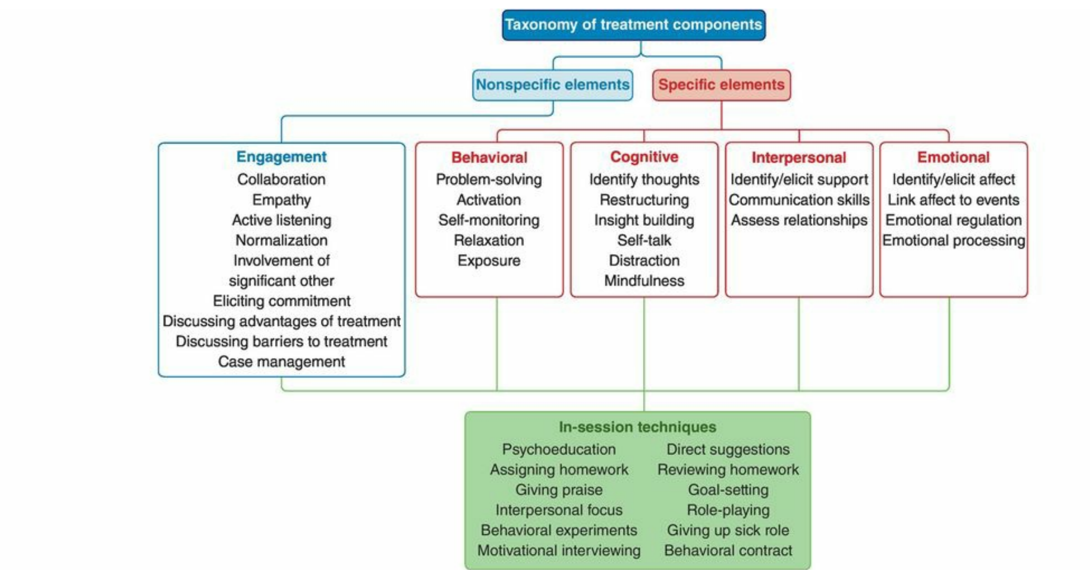

Figure 10.3 Treatment Elements Commonly Offered by Non-Specialist Providers

This figure illustrates the treatment elements most commonly offered by NSPs in low- and middle-income countries (Singla et al. (2017). Notice that many of these elements are treatment processes found in evidence-based treatment approaches, such as cognitive, behavioral and interpersonal therapy (see Chapter 9).

(Source: Singla, D. R., Kohrt, B. A., Murray, L. K., Anand, A., Chorpita, B. F., & Patel, V. (2017). Psychological treatments for the world: Lessons from low-and middle-income countries. *Annual Review of Clinical Psychology*, *13*, 149–181.)

Prevention Science

The worldwide treatment gap would obviously disappear if we could prevent mental disorders from ever developing. Decades ago, using principles borrowed from the field of public health, Canadian psychiatrist Gerald Caplan (1964) described three levels on which the ambitious goal of preventing mental health problems can be pursued: tertiary, secondary, and primary. Later, the Institute of Medicine (1994; now the National Academy of Medicine) suggested terminology which has now become more common: *indicated prevention interventions*, *selective mental health prevention*, and *universal mental health prevention*. The following definitions reflect both sets of terminology:

- **Tertiary prevention (indicated prevention intervention)** seeks to lessen the severity of disorders and to reduce short-term and long-term consequences of mental health problems. One example of this type of prevention, *psychosocial rehabilitation*, teaches clients with severe psychopathology how to cope better with the effects of their problems and tries to help them achieve the highest possible quality of life in the community and thus prevent further negative effects (Mihalopoulos et al., 2011).

Tertiary prevention (indicated prevention intervention)
Efforts to lessen the severity of disorders and to reduce their short- and long-term consequences.

- **Secondary prevention (selective mental health prevention)** involves interventions for people who are at risk for developing a disorder. Effective secondary prevention requires knowledge of how risk factors culminate in specific disorders. It also usually requires assessment methods that are reliable and valid for detecting the initial signs of an emerging problem so that attempts can be made to intervene as early as possible. Many secondary prevention programs attempt to increase protective factors for individuals who are at risk for the development of a problem, a process that is likely to increase the resilience of individuals in the program (Mihalopoulos et al., 2011).

  Secondary prevention (selective mental health prevention)
  Efforts to intervene with people who are at risk for developing a disorder.

- **Primary prevention (universal mental health prevention)** involves avoiding the development of disorders by either modifying environments or strengthening individuals so that they are not susceptible to those disorders in the first place. Primary prevention programs seek to counteract risk factors and reinforce protective factors (Mihalopoulos et al., 2011).

Primary prevention (universal mental health prevention)

Efforts to modify environments or strengthen individuals' resilience so that they are less susceptible to developing mental health problems.

These three types of prevention programs differ largely in terms of their target populations. For example, to prevent the recurrence of child abuse, a *tertiary* prevention program would identify parents who have abused their children in the past, and then arrange for them to attend psychoeducational classes on more effective ways of dealing with children's behavior, along with child development classes, both of which would help them become more informed, competent parents. Anger management classes might be offered as well. A *secondary* prevention program would offer help to a population of parents who are identified as being at risk for abusing their children (e.g., parents who had been physically abused themselves) but who have not yet done so. These parents might be paired with a well-functioning parent in their community who could act as a source of support and helpful information about dealing effectively and nonviolently with children's challenging behaviors. *Primary* prevention efforts would involve the entire community population and might include a public-service campaign on radio, television, billboards, and in newspapers in which celebrities, prominent athletes, and other influential figures would discourage child abuse and direct people to get help for child-rearing difficulties.

The focus of prevention, which is now known as *prevention science*, has been influenced at all levels by the development of the National Institute of Mental Health's Prevention Intervention Research Centers (PIRCs), and by recommendations contained in a number of government reports over the years, including reports by the National Research Council and National Academy of Medicine (2009a, b). There are prevention programs for many problems, such as depression (Muñoz, Beardslee, & Leykin, 2012), childhood obesity (Haynos & O'Donohue, 2012), eating disorders (Machado & Rodrigues, 2019; Stice, et al., 2013), alcohol abuse (Labbe & Maisto, 2011), delinquency and criminal behavior (Deković et al., 2011; Shure & Aberson, 2005; Welsh & Farrington, 2007), dating violence (Miller et al., 2012), and PTSD (Adler et al., 2009). The most ambitious programs are aimed at primary prevention through social system change. Here are just three examples:

Changing Environments. Primary prevention can entail efforts to make environments (such as homes, schools, and neighborhoods) more supportive of adaptive behavior. For example, programs such as Head Start that expand preschool opportunities and increase the commitment of parents and children to academic success have been shown to decrease antisocial behavior in the long run, even though this was not their original goal (Ripple & Zigler, 2003). Researchers are also seeking ways to make social environments more nurturing, thus supporting people's growth and well-being (Biglan et al., 2012).

Reducing Stress. Primary prevention can also take the form of efforts to reduce environmental stressors. For example, increasing the availability of affordable housing can reduce the frequency of household moves, a major

stressor for poor families that has been linked to psychological maladjustment (Rogers et al., 2012; Yoshikawa, Aber, & Beardslee, 2012).

Promoting Empowerment. There are primary prevention programs designed to *empower* individuals who have been marginalized as a result of age, poverty, homelessness, ethnic or sexual minority status, physical disability, or other factors. Empowerment means helping people to believe that they can do more to control their own lives and demand their rights (Rappaport, 2002). Some evidence suggests, for example, that empowering ethnic minority parents to influence school policies or empowering neighborhoods to control crime can have long-term mental health benefits for the community as a whole (Zimmerman, 2000).

Empowerment efforts have also begun to focus on promoting *mental health literacy* by educating the public about mental health issues and how to deal with them (Jorm, 2012). This trend is consistent with the attempts by many community psychologists, preventionists, and clinical psychologists to decrease the stigma associated with having mental health problems (Abdullah & Brown, 2011; Corrigan & Shapiro, 2010).

Community Psychology

Much of the impetus for prevention science came from the field of **community psychology**, whose practitioners advocate for treatment of mental health problems in clients' own communities, promote awareness and understanding of those problems, and work for social changes that can prevent them. Community psychology emerged in the 1960s in response to dissatisfaction with several aspects of traditional mental health care. In addition to concerns about the growing treatment gap (Albee, 1959), there was disenchantment with the then-dominant psychodynamic approach to therapy (Rappaport, 1977); skepticism about the reliability and validity of using the DSM for diagnosing disorders (Rosenhan, 1973); and doubts about the benefits of both one-to-one psychotherapy and psychiatric hospitalization (e.g., Eysenck, 1952). Questions raised about the possible harm being done to people who were held for years in large, state mental hospitals eventually led to passage of the Community Mental Health Centers Act in 1962, which provided funds for the construction of comprehensive mental health centers where even severely disordered clients could be treated in their communities.

Community psychology
A field whose practitioners promote community-based treatment of mental health problems, better understanding of those problems, and social changes that can prevent them.

Today, community psychology boasts its own division within the American Psychological Association, and there are several journals —including the *American Journal of Community Psychology*, the *Community Mental Health Journal*, and the *Journal of Community Psychology*—devoted to reporting the research and accomplishments of community psychologists. There are also a number of graduate training programs in community psychology, some of which are part of clinical psychology programs.

Principles and Methods of Community Psychology. One of the primary goals of community psychology is to understand the broad range of causes of psychological disorders, including problems in society such as poverty and discrimination, and to use primary prevention to modify community-level causes before they negatively influence individuals and groups (e.g., Bullock, 2019; Seidman & Tseng, 2011). Their efforts are based on an *ecological perspective*, which suggests that people's behavior develops out of their interactions with all aspects of their environment: physical, social, political, and economic. Their emphasis on primary prevention often leads community psychologists to encourage local citizens to use their voices to try improving conditions in their own communities through social activism. To accomplish social reform via a social justice approach, community members collectively use their power, which may be economic, political, or the power of civil disobedience. Advocates of social activist approaches argue that confrontation can be a key component of effective efforts to promote change. Opponents argue that such activity is value-laden and therefore incompatible with the objective empiricism that is a defining characteristic of a psychological scientist.

A less controversial aspect of community psychology involves evaluating efforts to promote mental health using *community-based*

participatory research (*CBPR*). In this kind of research, genuine partnerships are forged between researchers, organizational representatives, and community members, such that all partners are able to contribute their own areas of expertise and have a strong voice in how the research is done. Testing interventions through CBPR is intended to benefit community members and meet their needs, rather than having researchers impose those interventions from outside, which has been a common problem in the past (Rappaport, 2011).

Self-Help

Self-help programs for mental health problems have been around for decades, and their growing popularity has led some to suggest that they may soon rival all other forms of therapy (Harwood & L'Abate, 2010). Indeed, for many people, self-help programs already are a primary source of psychological advice and treatment (Norcross et al., 2003), partly because these programs overlap so much with some of the technology-based interventions we described earlier. One of the earliest of the self-help programs was Alcoholics Anonymous (AA), whose members meet regularly to exchange helpful information, provide social support, and discuss mutual problems (Coleman, 2005). With the advent of the internet, however, self-help groups can now "meet" remotely, including through social media outlets such as Facebook. In fact, the majority of self-help programs and resources are now being accessed online (Norcross, 2006).

Although **self-help** is usually defined as individual or group efforts to manage mental health problems without professional help, the term can also include interventions that—while not driven primarily by a mental health professional—may still involve some professional input. For example, in one therapist-facilitated support group for Asian American men (Chang & Yeh, 2003), members provided each other with information, guidance, and support about matters related to race, culture, gender, and well-being. The professional who organized the group monitored the discussion and suggested links to sources of information, but the content of the conversation was driven mainly by the participants. In other self-help groups, a professional might do little more than orient new members and act as a

consultant. In other words, it is not obvious where the boundary lies between traditional self-help programs and low-intensity, therapist-involved or NSP-delivered, interventions.

Self-help
Individual or group efforts to manage mental health problems without professional help.

Of course, some forms of self-help really do involve people tackling their problems on their own. Many of these people take advantage of *bibliotherapy*, which involves reading about how to deal with psychological problems. It constitutes a large component of the self-help movement, as you can easily see by strolling or scrolling through your local or online bookstore. Some self-help books, such as *Feeling Good: The New Mood Therapy* (Burns, 2008), are based on research in cognitive therapy or other treatment principles, but many others are not. So some of these books convey information that can be misleading and even harmful. The vast majority of self-help books are not written by experts, and the fact that they are published is no guarantee of high quality. Even when a book (or other self-help intervention) is based on a research-supported therapy method, the value of using that method without professional help is unlikely to have been tested (Rosen, Glasgow, & Moore, 2003).

It is not easy to choose wisely among the thousands of self-help books available, but advice is available. Professional clinicians themselves can

provide valuable guidance; one survey found that 82% of therapists recommend high-quality self-help materials to their clients as a supplement to treatment (Norcross, 2006). Some clinicians have even written self-help guidebooks. One of them, *Authoritative Guide to Self-Help Resources in Mental Health* (Norcross et al., 2003), summarizes the views of professionals about the value of various self-help books, groups, and internet sites for dealing with a variety of disorders. Another one, *Self-Help in Mental Health: A Critical Review* lists self-help programs, online resources, and books that empirical research has shown to be effective (Harwood & L'Abate, 2010). Recommendations are also available from a number of organizations that review some of the most prominent self-help offerings (e.g., http://www.abct.org/SHBooks/). Remember, though, that the self-help landscape is changing and growing so rapidly that there are always new options that may or may not have been evaluated.

So it is a good idea to be cautious, but not cynical. There is a growing body of research that supports the value of some bibliotherapy methods and online resources for problems such as mild depression, anxiety, eating disorders, gambling, and mild alcohol abuse (Apodaca & Miller, 2003; Carlbring & Smit, 2008; Harwood et al., 2011a; Haug et al., 2012; Lynch et al., 2010; Mains & Scogin, 2003; Morgan, Jorm, & Mackinnon, 2012; Newman et al., 2011; Varley, Webb, & Sheeran, 2011; Wilson & Zandberg, 2012). Like mental health professionals, one should keep an open mind about self-help resources and focus on identifying those whose value has been established by empirical evidence, not just the latest media trends (Norcross, 2006).

Complementary and Alternative Medicine

Self-help forms part of yet another approach to mental health-care delivery known as **complementary and alternative medicine (CAM)**, or *integrative techniques*. The wide range of CAM techniques includes herbology (over-the-counter herbs for improvement in well-being), chiropractic treatment, acupuncture, meditation, massage therapy, nutritional interventions (healthier diets and vitamin supplements), applied kinesiology, and biofeedback (Park, 2013), among others. In other words, CAM is an umbrella term for health-linked practices that, for the most part, are not typically part of well-researched, standard health-care programs. CAM is constantly being evaluated, however, and when research evidence begins to establish the benefits of particular methods, those methods find their way into more "mainstream" therapies. This is what happened in the case of mindfulness and acceptance which, though once considered to be in the realm of spirituality and CAM, are now part of the "third-wave" approaches to cognitive behavior and acceptance-based therapies that we discuss in Chapter 9.

Complementary and alternative medicine (integrative techniques)

An umbrella term for health-linked practices that are often not part of well-researched, standard health-care programs.

CAM techniques are widely used. One study of about 23,000 adults in the United States found that 44.8% of them had tried a CAM technique within the past year—either for symptom relief or for health promotion (Davis et al., 2011). One survey found that 56.7% of individuals with anxiety and 53.6% of those with depression were using CAM techniques on their own to help combat their symptoms. Further, about 66% of clients who were receiving traditional psychological treatment for these disorders were also using CAM methods (Kessler et al., 2001).

Many CAM techniques, such as acupuncture, have been around for centuries, but researchers have only recently begun to evaluate their effectiveness via controlled experiments. In the United States, there is now a National Center for Complementary and Alternative Medicine at the National Institutes of Health, and a great deal of federal grant money is being used to investigate a variety of CAM techniques. Some of these studies indicate that certain CAM techniques—many of which are used in conjunction with traditional psychological or medical treatments—can indeed be effective (Lake, 2009; Qureshi & Al-Bedah, 2013). Some of the more promising of these techniques involve the use of omega-3 essential fatty acids to reduce symptoms of depression (Freeman et al., 2010) and to lessen the likelihood of suicide attempts in people who have made previous attempts (Hallahan et al., 2007); yoga combined with cognitive behavior therapy to treat eating disorders in adolescents (Carei et al., 2010); and meditation in addition to standard treatments for children with a variety of disorders (Black, Milam, & Sussman, 2009). Many other CAM techniques remain incompletely evaluated, and those that do show promise will be studied further to determine which techniques are helpful for which difficulties.

We already know, though, that some CAM techniques, including a

number of “new age” therapies, are not only ineffective but can actually be harmful (Lilienfeld, 2007). Two techniques in this category are recovered memory therapy (in which therapists try to “help” clients recall allegedly repressed experiences of abuse) and rebirthing and reparenting therapy (in which therapists provide a new “birth experience” for clients by forcing them to spend hours working their way through confined spaces symbolic of the birth canal (Lynn et al., 2003). Although these therapies have been fully discredited, others like them (which also have no empirical support and likely have harmful effects) frequently appear on the professional horizon (Pignotti & Thyer, 2015).

As is the case with self-help, empirically oriented clinical psychologists remain open-minded about the possible usefulness of new CAM treatments, but they tend to stick to established interventions whose efficacy and effectiveness have been empirically supported and to await the same support for new CAM methods before adopting them. They pay particular attention to the plausibility of the mechanisms proposed to explain how new interventions are supposed to work (Lilienfeld, 2011), and are skeptical of those whose alleged mechanism runs counter to well-established scientific principles.

More information on both promising and discredited CAM methods is available in a number of books, such as *Complementary and Alternative Treatments in Mental Health Care* (Lake & Spiegel, 2007), *How to Use Herbs, Nutrients, and Yoga in Mental Health Care* (Brown, Gerbarg, & Muskin, 2012), and *Consumer Health and Integrative Medicine: A Holistic View of Complementary and Alternative Medicine Practice* (Synovitz & Larson, 2018) as well as in the *Journal of Alternative and Complementary Medicine*.

In Review Alternatives to In-Person Therapy with Mental Health Professionals

Approach	**Description**
Technological innovations	eHealth, mHealth, or digital therapeutics use technology such as web-based or app-based interventions, to reduce the need for face-to-face mental health services.
Use of non-specialist providers (NSPs)	Training nonprofessionals to deliver specific kinds of mental health care, thus increasing clients' access to mental health services.
Prevention	Attempts to decrease the incidence of mental disorders by counteracting risk factors and strengthening protective factors.
Community psychology	Interventions aimed at improving mental health by creating social changes, including empowering community members to advocate for conditions that promote healthy functioning.
Self-help	Efforts by groups and individuals to address their own mental health problems, sometimes through bibliotherapy, and usually without guidance from professionals.
Complementary and alternative medicine	Widely used mental-health-linked practices such as meditation, yoga, and herbal medicine that are not typically part of well-researched, standard health-care programs.

Test Yourself

1. One of the obvious advantages of training NSPs to deliver mental health services is that client waiting times can be _________.

2. Online college courses are the educational equivalent of ___________.

3. ________________ is the most wide-reaching level of prevention science.

You can find the answers in the Answer Key at the end of the book.

Chapter Summary

The mental health field has come a long way since the days when it offered little more than one-to-one in-person therapy. Though that format is still the dominant one, recognition of the treatment gap and need to develop more efficient models to deliver care has greatly increased the available service delivery options, including interventions conducted with couples, groups, and families. These interventions adapt the features and methods of individual psychotherapy for use in these special formats, where the focus is on supportive group processes and the social contexts in which problems are embedded.

The nature of mental health service delivery is changing in other ways, too. Current worldwide trends suggest that the near future will see less reliance on in-person therapy and the expansion of delivery models capable of reaching more of the people who need mental health services. These models include: (a) the use of trained non-specialist providers who can offer interventions at easily accessible locations, such as schools, medical/primary care clinics, day-care centers, and workplaces; (b) self-help options; and (c) programs aimed at prevention of mental health problems. Further, as telecommunication technologies become ever more widely available and affordable, opportunities for clinical psychologists to deliver technology-based health care will continue to expand, as will other technology-based interventions that don’t rely on mental health professionals. Despite the need to attend to potential ethical and legal issues related to technology-based

services, these services are clearly positioned to lower some of the barriers that currently stand between people and the mental health care they need.

As the range of mental health-care delivery models rapidly expands, choosing the right approach can be difficult, partly because many newer programs have not yet been well tested. Potential clients should seek information about which programs have the strongest research support for their effectiveness. Some clinical practice guidelines include overviews of research on technology-based services or various self-help or complementary/alternative medicine approaches, but this is still not the norm. Another option is to visit PsyberGuide.org, which offers evaluations of some popular web- and app-based programs.

11

Clinical Psychology for Youth and Older Adults

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Contents

A Brief History of Clinical Child Psychology

Unique Characteristics of Clinical Child Psychology

Clinical Assessment of Children

Treatment and Prevention of Child and Adolescent Disorders

The Future of Clinical Child Psychology

Clinical Geropsychology

Unique Characteristics of Clinical Geropsychology

Clinical Assessment of Older Adults

Treatment of Older Adults

The Future of Geropsychology

Chapter Preview

In this chapter, we tell you about two specialized fields of clinical psychology, namely clinical child psychology and geropsychology. We provide a brief history of each field and describe the unique features of the assessment methods that clinicians use with clients who are young, and those who are old. We also describe some of the most common disorders of childhood, adolescence, and old age, and some of the empirically supported treatments that are available to address these problems.

Suppose you are working as a restaurant server and that Rachel Jackson's father, James, happens to be one of your customers. When he learns that you are a psychology major, he asks what you think might be wrong with his niece, Ella, who has recently been acting like a bird. She built herself a "nest" with boxes and blankets in her bedroom, she often chirps rather than talks, and she will only eat spaghetti and other things that look like worms. You explain that you are not a qualified clinical psychologist, but you can't help being curious, and your growing knowledge of psychology prompts you to ask the most clinically important question about Ella: How old is she?

If she is three, like other young children, Ella is probably just engaging in imaginative play; pretending to be an animal for short periods of time is common and pretty adorable at that. If the niece is 12, however, it would be appropriate to have a clinical child psychologist conduct an assessment to explore her ability to tell reality from fantasy, ask about family history of psychopathology, check for any recent

traumas or substance use, and see how she is doing in school and with her peers.

It’s All About Age

Fantasy play, including temporarily adopting animal identities, is normal for young children, but not for adolescents.

(Source: Fotostorm/E+/Getty Images.)

In other words, knowing a child’s age and developmental level is essential for understanding the meaning of the child’s behavior, and determining whether or not the behavior reflects a psychological problem. Age and developmental level also influences the way a child’s disorders are treated by specialists in **clinical child psychology**.

Clinical child psychology
A subfield of clinical psychology focused on studying, assessing, treating, and preventing psychological disorders of children and adolescents.

A Brief History of Clinical Child Psychology

Section Preview This section highlights the ways in which the history of clinical child psychology differs from that of adult-oriented clinical psychology. We give special attention to the history of diagnosing childhood disorders.

The history of clinical child psychology reveals something of a paradox. As described in Chapter 2, clinical psychology has its roots in the assessment and treatment of childhood disorders, but for much of the 20th century those disorders were largely overlooked in favor of adult problems (Rubinstein, 1948). Indeed, the study of childhood disorders was, for a long time, simply "a downward extension and extrapolation from the study of psychopathology in adults" (Garber, 1984, p. 30).

This adult-oriented perspective on childhood disorders reflects the history of the concept of childhood itself. Not that long ago, children were considered and treated as miniature adults. This "adultomorphic" view was reflected in the first *DSM*, published in 1952, which included no disorders specific to youth. The 1968 edition (*DSM-II*) did include a section on disorders of childhood and adolescence, but contained only a handful of diagnoses (e.g., learning disturbances, hyperkinetic reaction, runaway reaction); most diagnoses were still far more appropriate for adults rather than for youth. In those days, psychotherapy methods, too, tended to downplay the unique nature of childhood problems (Gelfand & Peterson, 1985). Swiss developmental psychologist Jean Piaget (1896–1980) was among the first to point out that young children are not miniature adults in

their thinking, that they conceptualize the world in fundamentally different ways than adults do.

Since Piaget's time, it has become increasingly obvious that traditional adult-oriented methods of classification, assessment, and intervention may not necessarily apply to childhood disorders. Clinical child psychologists now recognize and study the ways in which the symptoms of disorders such as depression may differ in children and adults. They also now realize that in order to be successful, treatments must take into account a child's developmental level.

The importance of developmental factors was reflected in the 1980 *DSM-III*, which included developmental considerations in the diagnostic criteria for some disorders. This allowed a particular pattern of behavior to be diagnosed differently, depending on a patient's developmental level. *DSM-IV* (1994) contained more than two dozen disorders specific to infants, children, and adolescents, and as you know if you have taken a course in abnormal psychology, *DSM-5* (2013) has infused developmentally sensitive criteria into nearly all disorders. When reading these criteria in search of a diagnosis, clinicians are reminded to consider whether the child is displaying more symptoms than would be expected given the child's age and developmental level.

The idea that developmental factors are vital in understanding, diagnosing, and treating disorders in children and adolescents had begun to gain traction even before it appeared in the *DSM*. As early as 1970, new journals dedicated to clinical child psychology began to appear, and now there are many of them (see Table 11.1). By 2000, there were two new divisions of the APA devoted entirely to children's behavioral, learning, and medical problems: Division 53 (Society of Clinical Child and Adolescent

Psychology) and Division 54 (Society of Pediatric Psychology). There are also graduate programs in which students can specialize in clinical child psychology (Jackson, Alberts, & Roberts, 2010); see the database on the APA Division 53 website. Finally, a relatively new field of study known as **developmental psychopathology** has evolved (Masten, Burt, & Coatsworth, 2015). Researchers working in this field focus on how adaptive and maladaptive patterns of behavior show themselves across childhood and adolescence and how they are influenced by an individual's developmental stage. Developmental psychopathologists also study how children develop competencies as well as disorders. Their goal is to identify protective factors that prevent children who are at risk for disorders from developing them (Masten, 2018).

Table 11.1 Selected Clinical Child Psychology Journals

Development and Psychopathology; *Journal of Abnormal Child Psychology;* *Journal of the American Academy of Child and Adolescent Psychiatry;* *Clinical Child and Family Psychology Review;*	*Journal of Child Psychology and Psychiatry;* *Journal of Clinical Child and Adolescent Psychology;* *Journal of Family Psychology;* *Child Psychiatry and Human Development*

Developmental psychopathology

A research field focused on maladaptive behaviors in childhood and adolescence and how they are influenced by developmental

stages.

Why, after so many years of neglect, is so much attention now being devoted to child psychopathology? One source of motivation comes from research showing that many childhood disorders carry lifelong consequences. By studying the risk factors, causes, and courses of childhood disorders, we may be better able to develop interventions that prevent childhood problems from escalating and extending into adulthood. A second influence is media attention devoted to certain high-profile, child-related problems, such as bullying and suicide, and the increased rates at which doctors are prescribing psychotropic medications for children. This publicity has led to the establishment of a number of national task forces, a Surgeon General's report on children's mental health (U.S. Department of Health and Human Services, 2000), and White House conferences devoted to childhood mental health. In short, the field of clinical child psychology has grown and is now a well-established specialty within clinical psychology.

In Review A Brief History of Clinical Child Psychology

<table>
<tr><td>Historical view of children</td><td>As miniature adults</td></tr>
<tr><td>Implications for childhood disorders</td><td>Few diagnoses with developmental perspectives or criteria.</td></tr>
<tr><td>Changes appearing in DSM-5</td><td>Age of onset and course provided.
Some symptoms are expressed differently for children.
Reminders to consider whether behavior is developmentally inappropriate.</td></tr>
<tr><td>Clinical child research and training</td><td>Appearance of specialized journals in clinical child psychology.
Training programs in clinical child psychology.
Two divisions of APA devoted to this topic.</td></tr>
<tr><td colspan="2">Test Yourself
1. The DSM included no childhood disorders until which version?
2. The study of how childhood disorders are influenced by the individual’s developmental stage is called _________.
3. High-profile social trends such as _______ have helped motivate research and treatment aimed specifically at disorders in children and adolescents.
You can find the answers in the Answer Key at the end of the book.</td></tr>
</table>

Unique Characteristics of Clinical Child Psychology

Section Preview We review a number of characteristics unique to clinical child psychology, including the importance of considering the child's developmental stage, the influence of social contexts on children's behavior, the processes through which children receive help, and matters related to professional ethics.

Because children are not just miniature adults, clinical psychologists who work with them and their families must remain mindful of a whole variety of factors that make clinical child psychology unique. Let's review these factors.

A Focus on Developmental Stages

As illustrated earlier in relation to Ella Jackson's identification as a bird when she was 3 years old, clinical child psychologists know that they must consider their clients' developmental stage if they are to understand a child's behavior. The need to do so is probably the main thing that makes clinical child psychology unique. Although development continues across the life span, the developmental stages seen in children occur more quickly than in young, middle-aged, and older adults. These rapid changes mean that there can be dramatic differences in the behavior that children can be expected to display, even over a few short months. As a result, clinical child psychologists—and students training for this field—must have a firm foundation of knowledge about what typical development looks like. For example, they need to know when infants, toddlers, children, and adolescents typically reach various developmental milestones, from crawling to talking to engaging in logical thinking. These milestones reflect physical, cognitive, emotional, and social development (Beauchaine & Hinshaw, 2017; Phares, 2013).

A clinician's knowledge of typical development has many implications for the assessment and treatment of psychopathology. First, it is important to know what typically developing children in the same developmental stage can do in order to determine whether a particular child's behavior is atypical. This is not an easy task. Most symptoms of childhood disorders are seen in a significant proportion of children at some point, so the appropriateness or inappropriateness of children's behavior must be evaluated with great care (Achenbach, 2008b). Asking parents[1] can tell only part of the story because it can be quite difficult for them to have the objectivity to evaluate their own

child. They may also not have enough perspective to know what is "typical" behavior at their child's age; they can only rely upon their own experience and perhaps that of other parents they know. For example, virtually all toddlers have short attention spans and limited impulse control, but how can a mother know whether her toddler's attention span and impulse control differ enough from national norms as to place the child at risk for a diagnosis of attention-deficit/hyperactivity disorder (ADHD)? This is the kind of assessment question that is often addressed by clinical child psychologists.

Clinicians' knowledge of typical development in childhood and adulthood also comes into play when it is time to explain a child's problem, and the recommended treatment, to children and their parents in ways that each can understand and that will increase the chances that everyone will be motivated to participate. Making sure that clients understand these explanations is yet another aspect of the ethical responsibilities of clinical psychologists that we discuss in Chapters 1 and 15.

Attention to the Contexts of Behavior

Children's behavior takes place in an environmental context, such as home or school or the playground, and their behavior is influenced by the structure and demands of that environment. This is also true of adults, of course, but there are at least two reasons why keeping the environmental context in mind is especially important when dealing with children.

First, children's behavior is generally more malleable, and thus more subject to environmental influence than that of adults, whose behavior patterns have typically been well-established. So for children, the environment can act both as a risk factor for psychopathology and a protective factor against it. For example, having peers who use drugs can be a risk factor for the onset of an adolescent's own drug use, but a relationship with a trusted adult at school can mitigate this risk. Second, whereas adults can decide where they live, when they go to bed and wake up, with whom they spend their time, what they eat, and how they run their lives, children and adolescents have far less control over these things; sometimes they have no control. Younger children, especially, must live with the decisions that their parents make for them about things like day care or schools, food options, daily routines, and access to activities and other children as potential friends.

The influence of environmental contexts on children's behavior must be taken into account when conducting clinical assessments with children. Children may not only be more influenced by environments than adults are, but also show more variability than adults do from one context to another. Therefore, as you will see in the next section, clinical child psychologists

typically assess behavior in different contexts, and solicit reports from multiple informants who have observed the child in various situations. These clinicians want to know whether a child's behavior is typical at a particular developmental stage, and also whether it is typical of children at that stage in particular contexts.

Though environments play a particularly significant role in the appearance of child psychopathology, clinicians realize that, unlike adults, children typically have limited power to alter their environments. This is one reason why, as described later, the treatment of childhood disorders is typically conducted with the help of parents, and sometimes teachers. The goal, often, is to decide how best to structure the child's environment so as to reduce risk factors and/or enhance protective factors.

Processes for Seeking Help

Unless ordered by a court to seek professional help for psychological disorders most adults do so as the result of their own personal decision. For children, the picture is quite different. Those who feel distressed must depend on parents, teachers, or other significant people in their lives to determine whether they need the help of a mental health professional. They may get help, or they may not. In contrast, children and adolescents such as Rachel Jackson, who may not see themselves as having problems, may nevertheless receive mental health services because parents, teachers, or others believe that the services are needed. Sometimes, children are referred to a mental health professional for reasons that have more to do with parental or family problems than with the child's emotional or behavioral characteristics (Kaslow, 2011). This situation can create significant challenges for clinical child psychologists' assessment and treatment activities.

Confidentiality

Clinicians who work with adults know that they cannot ethically share information about their clients with anyone else except in cases involving suicidal or homicidal intent or abuse of a child or an elderly, incapacitated person. But what ethical standards apply when the client is a child or an adolescent? Officially, parents or legal guardians are responsible for these young clients, so clinicians' ethical obligation to maintain confidentiality does not prohibit them from disclosing client information to the client's parents or guardians (Koocher & Daniel, 2012). This may not create significant problems when the client is a young child, but it is a different story when clinicians work with older children, especially adolescents. If the clinician cannot promise to keep information secret from the client's parents, adolescents are likely to be wary of sharing any important information during assessment or treatment sessions.

To minimize this problem, clinical child therapists set ground rules at the outset of treatment. According to these rules, everything the adolescent client discloses will be kept private (even from parents) unless something about the client's behavior is potentially seriously harmful to the client or someone else. This guarantee is guided by the APA's ethical standards of psychologists outlined in earlier chapters.

In Review Unique Characteristics of Clinical Child Psychology

Characteristic	**Purpose, Rationale, or Consequence**
Emphasis on knowledge about typical development	To accurately determine what behavior is typical and atypical. To shape explanations of diagnosis and treatment so as to be understandable to children and their families.
Focus on the influence of environmental context on children's behavior	Contexts have greater influence for children than for adults. The need to assess children's behavior in multiple contexts.
Recognition that help-seeking processes are different for children than for adults	Children usually do not have the power to initiate or stop treatment.
Special ethical concerns	Clinicians can share information with parents or legal guardians about young child clients, but in the case of adolescents, most therapists keep information confidential unless the clients or others are in danger.

Test Yourself

1. A clinical child psychologist might become concerned if a child's development is atypical compared to appropriate ________.

2. The behavior of _________ is influenced ________strongly by environmental contexts than that of _______.

3. _____ are far more likely than _______to be forced to receive mental health services.

You can find the answers in the Answer Key at the end of the book.

Clinical Assessment of Children

Section Preview In this section, we review some of the special things that clinicians must keep in mind when conducting assessments of children rather than adults, and we highlight some of the assessment techniques they use, including behavior rating scales, clinical interviews, intellectual and achievement testing, and behavioral observations.

For both children and adults, the clinical assessment process is designed to serve a number of purposes, including arriving at a diagnosis, making treatment recommendations, predicting treatment outcomes, and evaluating the progress of therapy. However, as suggested in the previous section, there are certain things that clinical child psychologists must consider when conducting assessments with children.

Special Considerations in Child Assessment

First, because it is so important to understand a child's developmental stage when trying to determine if behavior is atypical or not, the majority of clinical assessment instruments are *normed*, meaning that raw scores on these measures are converted to a standard score based on the child's age (and sometimes also gender or other demographic characteristics). Using standard scores allows the clinician to compare a given client to other children of the same age and gender. For example, symptoms of anxiety are more commonly reported by younger children than older ones, so if an 8-year old and a 14-year old report the same number of symptoms, it is likely that the 14-year old would meet diagnostic criteria for an anxiety disorder. Knowing about a child's developmental stage and using appropriate norms is also vital when interpreting the results of the intelligence and achievement tests that are a routine part of the clinical child assessments. This is because children's intellectual development and academic abilities change quickly; even 3 months can make a difference.

Second, because the environment influences children's behaviors so strongly, clinical assessments of children tend to be more comprehensive than those of adults. The clinician must gather information from parents, teachers, and any other sources that can provide information about the child's behavior in all major life domains, including school, family, and peer group (Achenbach, 2008a). A clinician might conduct observations of the child's behavior as the child interacts with parents, teachers, and peers. Clinicians may even ask child clients to provide their own descriptions and perspectives

of behavior problems, although the weight given to these self-assessments will likely be greater for older children.

Because children’s emotional and behavioral status depends heavily on the nature of their family life, assessment will also include exploration of the lifestyles, mental health, and child-rearing and disciplinary practices of the parents (Mash & Hunsley, 2007). The clinician will want to know about any history of psychopathology in the family (including in the parents), the quality of the parental relationship and the degree of interparental conflict present, and the sources of support that are available to the child at home. There will also be questions about the physical environment, including sleeping arrangements, the number of family members and others who live in the home, and what behaviors are expected of the child. Suppose, for example, that a child’s mother tells a clinician that her son seems “hyperactive,” but the boy’s father, who is divorced from the mother but has joint custody, disagrees. Gathering more information about what goes on when the child is at each parent’s home can be enlightening. It may turn out that the child must do all his homework during the week, when he is with his mother, and can take it easy on weekends, when he is with his father. If the boy does have ADHD, the demands of concentrated homework will generate the symptoms his mother sees, but that his father would not see.

When collecting family background information, clinicians have to be careful to explain that it will be used to better understand the child and the child’s problems and to guide an effective treatment plan. Otherwise, parents are likely to assume that questions about their home life and behavior suggest that they are to blame for their child’s problems.

Let’s look now at the main methods clinicians use to gather their assessment data.

Behavior Rating Scales

Because they are inexpensive, easy to administer, and usually reliable and valid for their intended purposes (Frick, Kamphaus, & Barry, 2009), behavior rating scales have become a standard part of almost all child assessment batteries. As described in Chapter 4, these rating scales generally consist of a list of child behavior problems (e.g., fidgets, easily distracted, shy, starts fights). The rater indicates how often each behavior occurs, and because most behavior rating scales are normed, it is easy to compare the scores of the child being rated with those of other children at the same developmental stage.

Rating scales are nearly always completed by parents and at least one teacher. Children over the age of 6 years may be asked to make ratings of their own behavior, but because children may not be willing to report some aspects of their behavior, especially when it involves disruptive, impulsive, or aggressive acts, their ratings may not be valid for assessment purposes. Children's ratings of depressive or anxious feelings tend to be more accurate. Indeed, children may be even more aware of these feelings than their parents and teachers are, whereas parents are generally more accurate reporters of their children's disruptive behavior problems.

Behavior rating scales differ in their coverage, with some focusing on specific disorders (e.g., the *Child Depression Inventory-2;* Kovacs, 2010), whereas others cover a wide range of child behavior problems. The *Achenbach System of Empirically Based Assessment* (ASEBA; Achenbach & Rescorla, 2001) is an example of the latter type that is commonly used in

clinical research and practice. The ASEBA contains rating scales that can be completed by parents, teachers, and child clients (see Figure 11.1).

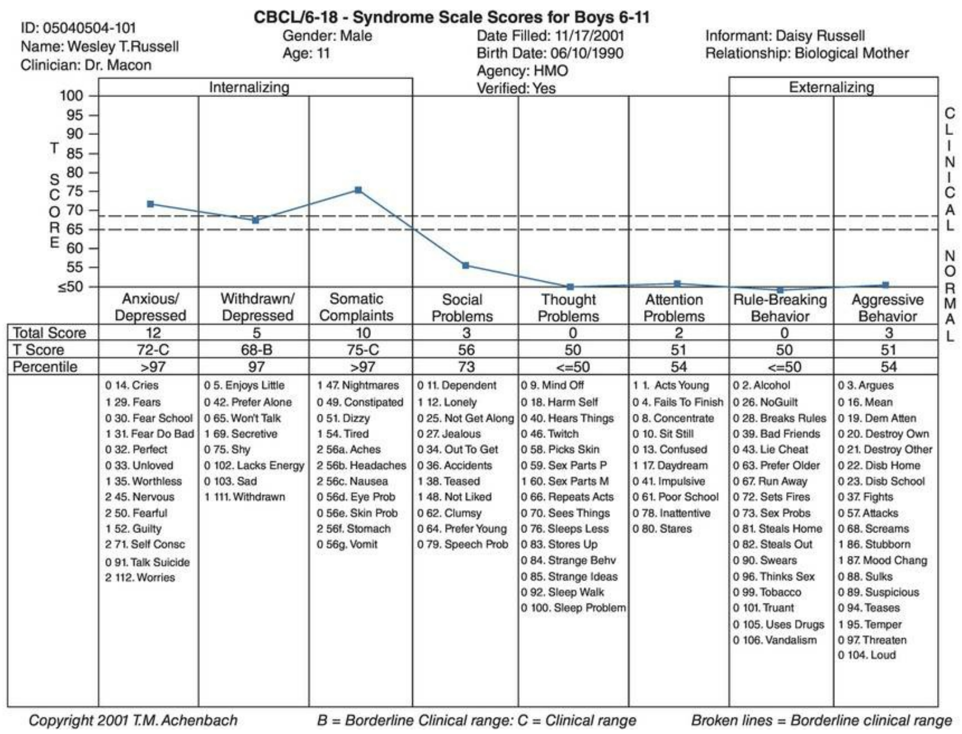


Figure 11.1 Syndrome Profile for "Wesley Russell" as Rated by His Mother

This example of ASEBA results shows a mother's ratings of her 11-year-old son, Wesley (not his real name), who was referred to a clinician for missing school excessively because of asthma and headaches (Achenbach & Rescorla, 2001). The profile shows that, compared to other boys his age, Wesley displayed clinically elevated levels of anxious/depressed, withdrawn/depressed, and somatic complaints.

(Source: Copyright Achenbach T. M. & Rescorla, L. A. (2001). *Manual for the Achenbach System of Empirically Based Assessment (ASEBA) school-age forms and profiles*. Burlington, VT: University of Vermont, Research Center for Children, Youth, and Families. Copyright 2001 by University of Vermont, p. 65. All names are fictitious. Reproduced by

permission.)

The ASEBA has strong psychometric properties, and converges well with other measures to distinguish between children with higher versus lower levels of behavior problems. Taken together, rating scales completed by parents, teachers, and child clients can provide an economical and efficient way to obtain reliable, valid, and useful assessment information.

Clinical Interviews

One survey of clinical child and adolescent psychologists found that 71% said that clinical interviews were the most important aspect of their assessment procedures (Cashel, 2002). As is the case with adults, these interviews can be unstructured or structured (see Chapter 4). Most clinicians interview parents as well as children, spending more time with child clients who are older and more cognitively mature. Less commonly, clinicians will interview teachers or family members other than parents.

Clinical interviews help to establish rapport between clinicians, clients, and their families, thus paving the way for parents and children to feel comfortable and willing to disclose details about the child's problem, and perhaps other family problems. Interviews also provide a way to collect additional details about the nature and history of a child's development and problems and to explore other factors in the child's life that may be contributing to those problems.

Interviews are important, too, for correcting any errors in rating scale data. For example, when rating children on ADHD scales, raters sometimes interpret "does not seem to listen when spoken to directly" to mean that the child chooses to be defiant, as opposed to possibly just daydreaming and missing a teacher's instructions, which is what the item is supposed to measure. Interviews can provide richer details about the child's behavior, which may help the clinician better understand what has caused the problem and what is maintaining it. Often, the result is more informed treatment recommendations.

Structured versus Unstructured Interviews. Unstructured interviews may be especially helpful for building rapport, and they are usually shorter than structured interviews. They also allow clinicians to ask questions that are relevant for diagnosis and treatment, but not related to specific symptoms of the disorder. For example, clinicians can use unstructured interviews to find out about differences between what parents and children see as the cause of a child's problematic behavior.

Nevertheless, many clinicians and most researchers use structured clinical interviews to help them arrive at diagnoses. Structured diagnostic interviews, such as the Diagnostic Interview Schedule for Children (DISC; Shaffer et al., 2000) present a fixed series of questions in a fixed order so as to check for the presence of symptoms of the many disorders as specified by *DSM* criteria. The results of these interviews lead directly to a diagnosis in a manner that is relatively reliable and valid. However, structured interviews can take a long time (e.g., 1.5 to 2 hours) and may not do much to enhance rapport. For these reasons, some clinicians opt for semistructured interviews, which ideally combine the clinical sensitivity and flexibility of the unstructured interview with the higher diagnostic reliability of structured ones. One example is the Semistructured Clinical Interview for Children and Adolescents (McConaughy & Achenbach, 2001).

Whether structured or unstructured, clinical interviews are usually not normed. As a result, clinicians must use their own judgment as to whether interview data suggest that a child's behavior is unusual or inappropriate for the child's developmental stage. As described in Chapter 3, such clinical judgments are often far from perfect.

Intelligence and Achievement Tests

Poor school performance accounts for a large number of child referrals for mental health services, partly because many children with academic difficulties also have behavior problems. Indeed, behavior problems and academic difficulties are related in complex and reciprocal ways in which behavior problems can impair academic functioning and academic difficulties can worsen behavior problems. Clinical child psychologists typically administer tests of intellectual abilities and academic achievement to better understand the nature and origins of academic difficulties. As described in Chapter 5, these highly standardized tests provide age-graded norms that allow a particular child's performance to be easily compared with other children.

The intelligence test most commonly used by clinical child psychologists is the Wechsler Intelligence Scale for Children-Fifth Edition (WISC-V; Wechsler, 2014). As described in Chapter 5, the WISC-V can be used with children aged 6 to 17, and yields a full-scale IQ score, five composite (index) scores (verbal comprehension, visual spatial, fluid reasoning, working memory, and processing speed), and individual subtest scores. The most commonly used achievement test for children in the United States is the fourth edition of the Woodcock–Johnson Tests of Achievement (WJ-IV; Schrank, McGrew, & Mather, 2014; see Chapter 5). The WJ-IV is used to measure knowledge that children have acquired in the educational environment. Children at different grade levels are assessed on different topics, but the main characteristics measured at all ages include broad reading, broad mathematics, and written expression.

Projective Tests

Some psychodynamically oriented clinicians seek to explore the personalities and problems of children and adolescents using some of the projective tests described in Chapter 5. The most popular of these are the Rorschach inkblot test (Rorschach, 1942), a version of the Thematic Apperception Test (TAT), called the Children’s Apperception Test (CAT) (Bellack, 1954), drawing techniques such as the House–Tree–Person technique (Buck, 1948), and incomplete sentence blanks (Rotter, Lah, & Rafferty, 1992).

Unfortunately, despite occasional exceptions (e.g., Leon, Wallace, & Rudy, 2007), the test–retest and interrater reliabilities for these tests are often unacceptably low, or even unknown, especially when used with children (Hunsley, Lee, & Wood, 2003; Wood et al., 2010). Further, there is little or no replicated evidence for the incremental validity of projective tests. In other words, even if they did allow valid inferences about children (e.g., that signs of aggression on the CAT predicted aggressive behavior), that same information is usually already available through interviews, observations, or other simpler and more reliable and valid means (Hunsley, Lee, & Wood, 2003). There are also few standardized ways of scoring projective tests, and a lack of norms makes it difficult to interpret responses in comparison with other children at the same developmental level.

Nevertheless, some clinicians continue to use projectives, often citing what they see as the tests’ usefulness with children who have difficulty either in answering orally presented questions or providing quantitative data on behavioral rating scales (Leon et al., 2007). Most clinicians, however, remain

concerned about the poor psychometric properties of these tests and the potential for biases or other errors that stem from those properties.

Behavioral Observations

Children's problems usually occur in the home or at school, so observations in these settings give clinicians the opportunity to validate, gain new perspectives on, and resolve discrepancies between reports made by parents and teachers through rating scales and interviews. When, for example, a mother describes her daughter as anxious and withdrawn, but the teacher fails to see these problems, a school observation might be indicated. That observation might reveal that the child does appear anxious and shy when she is dropped off at school, but then warms up quickly. This is an example of differing, but accurate, reports of behavior affected by social contexts. Observation might instead show that the child remains anxious all day, but that the teacher has so many students with more noticeable behavioral problems that a quietly anxious girl is not noticed.

School observation systems focus primarily on classroom behavior, although playground behavior also may be monitored (Lean & Colucci, 2013). Classroom observations often concentrate on behaviors associated with ADHD, including being off-task, disruptive, out-of-seat, or noncompliant (Lean & Colucci, 2013; see Figure 11.2).

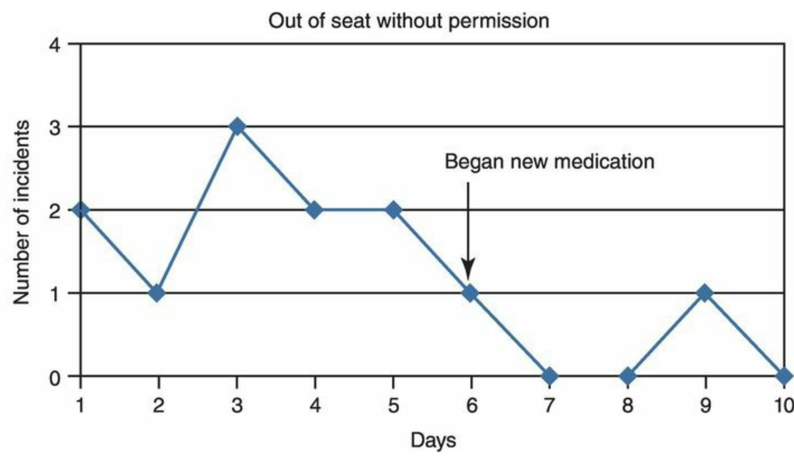


Figure 11.2 An Example of Data Collected from Classroom Observation Observations are sometimes used to track the behavioral results of a medication program.

(Source: Brown, R. T., Carpenter, L. A., & Simerly, E. (2005). *Mental health medications for children: A primer* (p. 89). New York, NY: Guilford.)

Some observational systems include structured scoring, but most are informal. For example, a clinician will usually compare how a child client's classroom behavior compares with that of the child's classmates and use that information to decide whether the child's behavior differs from what is typical in that environment. It is rare these days for clinicians to conduct home observations, but they do often set up opportunities to observe parent–child interactions in a clinic office or playroom (Frick, Kamphaus, & Barry, 2009).

Understanding and Dealing with Inconsistent Assessment Information

As you can now see, clinical assessments of children are usually comprehensive and time-consuming processes involving multiple informants whose information comes from rating scales, interviews, tests, and observations (De Los Reyes et al., 2015). Ideally, all these informants tell pretty much the same story, but more often than not this is not the case. The clinician has to consider why there is disagreement and which source or sources of information are likely to be most accurate.

They realize, for example, that informants might have reason to exaggerate or underreport a child's behavior problems. One parent may highlight problems to ensure that a child qualifies for mental health services, while the other downplays problems to keep the child from being stigmatized. Teachers' reports can be influenced by either of these same motivations. Parents embroiled in a contentious divorce might want a child to be seen as having—or not having—special needs that would alter alimony, child-support, or custody arrangements. Children themselves may overreport problems to get attention, or minimize them to avoid embarrassment. Even those who conduct behavioral observations may allow subjectivity to creep into their reports if the child they are observing elicits sympathy or annoyance.

These biases are not necessarily conscious. Parents and teachers, especially, may tend to see certain children in a generally positive or negative light that colors their view of everything those children do. Is a child being bossy or just standing up for herself? Did a child fail to do his schoolwork

because he is lazy or just didn't understand the assignment? Different informants (including supposedly objective observers) may make different judgments depending on their overall positive or negative bias. In short, clinicians must consider motivational factors in assessment data rather than simply accepting them at face value.

A second source of discrepant assessment data comes from differing interpretations of the terms used in behavioral rating scales. Consider this rating scale item: "often behaves aggressively." If the scale does not specify what "often" means, one rater might assume it means every day, while another thinks it means once a week. As mentioned earlier, clinical interviews with parents and teachers can correct discrepancies like this because the clinician can use knowledge about typical child development to determine whether a behavior is actually occurring "often" or not. A related source of disagreement in rating scale data is the fact that, like the rest of us, children have good days and not so good days. Ratings can be affected if a parent or teacher fills out the scale when the child has just behaved exceptionally poorly (or well). This same bias can also affect a clinician's observations if they happen to occur when a child is having a particularly bad day, or an unusually good one. This is why clinicians try to arrange for observations on multiple occasions whenever possible.

A final source of discrepant assessment information is the simple fact that, as mentioned in our discussion of environmental contexts, children sometimes do behave differently across situations, such as at home and at school. In these cases, "discrepant" information is not really discrepant, it is descriptive of an inconsistency whose sources a clinician will want to understand. When the factors underlying the inconsistency come to light, it becomes easier to plan effective treatment of the behavior that is problematic.

A Case Example

As an example of some of the special considerations that clinical child psychologists have to keep in mind when conducting assessments with children and adolescents, let's return to the case of Rachel Jackson. You will recall from Chapter 1 that 17-year-old Rachel has recently been hanging out with peers who routinely smoke marijuana, drink a lot of alcohol, and skip classes. Her grades have taken a nosedive and she has started a crash diet. Rachel's mother, Lena, contacted a school guidance counselor who referred Rachel to Dr. Cynthia Leon, a clinical psychologist. Dr. Leon's first goal is to establish rapport, and then to conduct a thorough clinical assessment.

As a first step in building that rapport, Dr. Leon recognizes that her client probably would not have come to treatment on her own. So rather than assuming that—like self-referred adult clients—Rachel is eager to begin assessment and treatment, Dr. Leon gives Rachel a chance to express her feelings about being in her office. She starts the first session by asking Rachel what she hopes to get out of the meeting, and is friendly and accepting of the answer, which is "to get my mother off my back." She expresses sincere interest in Rachel's opinion about her mom's "interference," and asks Rachel if there is anything that she wants to change about her life. As described in Chapter 3, Rachel says that she is unhappy about a recent romantic breakup and that she worries about being accepted by her new peer group, all of which have led to disrupted sleep, sad mood, and occasional thoughts of suicide. Dr. Leon asks if Rachel wants to try to feel better about herself and her social life. Rachel nods, but looks concerned. Sensing that Rachel is worried about confidentiality, Dr. Leon explains that

Rachel's parents have been told that everything Rachel says in therapy will be kept confidential unless there is a serious risk that she will harm herself or someone else.

With these concerns put to rest, Dr. Leon asks Rachel to complete the Beck Depression Inventory-2 (BDI-2), a questionnaire described in Chapter 5 that assesses depressive symptoms. Rachel's score on the BDI-2 is significantly higher than the average scores of other girls her age, so Dr. Leon follows up with a semistructured interview that focuses mainly on symptoms of depression. This assessment approach assumes that, at 17, Rachel is probably the best source of information about those symptoms, especially because she says she has not mentioned them to her parents. Nevertheless, Dr. Leon takes note of the fact that Rachel's guidance counselor reported her to be sullen and withdrawn, which serves as corroborating evidence.

Dr. Leon wonders what role that marijuana and alcohol play in Rachel's emotional life, so she asks the question in exactly those words. She could have asked if Rachel has a substance use problem, but that wording might have been heard as an accusation, harmed rapport, and led to denial. Instead, Rachel reveals that she uses alcohol and marijuana to "dull the pain," and also to fit in with her friends. She is not happy with herself, though, because her substance use has negative side effects, including hangovers, and problems with concentration. She worries, too, because she seems to be building tolerance—needing higher doses to get the same effects or experiencing weaker effects at the same dosages.

Dr. Leon's assessment then focuses on understanding Rachel's behavior in the context of her home, school, and neighborhood environments. She learns that dealing with the stress of recent unemployment and marital discord have left Rachel's parents—especially her father—less able than

before to adequately supervise their children. Indeed, even though Rachel says she wishes her parents would “leave me alone,” she also admits feeling sad because, other than “sending her to a shrink,” they tend to ignore her. Further, being biracial, Rachel feels that she doesn’t entirely fit in at her school, and that these feelings—and her desire to be accepted—have pressured her to conform to a certain ideal standard of beauty and to her peers’ substance use.

On the basis of all this assessment, Dr. Leon tentatively concludes that Rachel would be most accurately diagnosed with major depressive disorder and substance use disorder, but as described in Chapter 9, treatment also focused in part on addressing what may be an eating disorder.

In Review Clinical Assessment of Children

Special Considerations	Implications for Assessment
Children develop rapidly. Environments are especially influential	Behavior must always be interpreted in relation to what is typical at each developmental stage. Assessment must occur in multiple environments, and include information about many aspects of the home and family situation.
Assessment methods	Behavior rating scales Clinical interviews Intelligence and achievement tests Projective tests Behavioral observations

Test Yourself

1. Clinical child psychologists often use ___________ for assessment because they are inexpensive, easy to administer, and generally reliable and valid.

2. When a child assessment instrument includes information about the average scores of children at various ages, the instrument is said to have ________.

3. _______ offer the best opportunity to build therapist–client rapport while collecting assessment data.

You can find the answers in the Answer Key at the end of the book.

Treatment and Prevention of Child and Adolescent Disorders

Section Preview In this section, we first summarize some of the psychosocial therapies and psychoactive drug treatments being used to address the psychological and behavioral problems of children and adolescents. We then describe the results of research on these treatments, including their effects and side effects. Finally, we describe clinical child psychologists' efforts to prevent childhood disorders and their potentially devastating long-term consequences.

Among the most common childhood and adolescent conditions listed in the *DSM-5* are anxiety disorders, depression, attention-deficit hyperactivity disorder, autism spectrum disorder, and disruptive disorders such as conduct disorder and oppositional defiant disorder. Treatment of these disorders differs in important ways from the clinical interventions for adults. As in the assessment of children, child therapy poses special challenges because children and adolescents usually do not—or cannot—refer themselves for help; their contact with a therapist requires parental motivation and cooperation. However, like the adult therapies discussed elsewhere in this book, child and adolescent therapies can be based on psychodynamic, behavioral, cognitive behavioral, or family-systems approaches. Rather than reviewing each of those general approaches here, let’s focus on more specific interventions that research suggests work best.

Psychosocial Treatments for Disorders in Children and Adolescents

As has been the case for adult forms of psychotherapy, many task forces, outcome studies, reviews, and meta-analyses have tried to establish which treatments are most efficacious in helping children and adolescents with mental health problems (e.g., Evans et al., 2018; Jones et al., 2019; LaGreca, Silverman, & Lochman, 2009; Reynolds et al., 2012, Wang et al., 2017; Weisz, Doss, & Hawley, 2005). These outcome summaries have found that, overall, psychosocial treatment of children's disorders is beneficial, showing effect sizes ranging from 0.7 to 0.8. This means that on average, treated children improve about 0.7 to 0.8 of a standard deviation relative to untreated children. These effect sizes are comparable to those found in analyses of adult treatment.

Some therapies are better than others for certain conditions, though. Some of those whose efficacy in treating children's and adolescents' mental health problems have been "well established" by research evidence are displayed in Table 11.2.

Table 11.2 Evidence-Based Psychosocial Treatments for Selected Child and Adolescent Disorders

As is the case for adult disorders, the majority of "well-established" treatments for childhood and adolescent disorders fall into the behavioral, cognitive behavioral, and interpersonal domains (see Chapter 7). For more details about these disorders, we suggest taking a course on psychopathology or consult an abnormal psychology textbook (e.g., Burke, Trost, deRoon-Cassini, & Bernstein, 2016).

Name and Description of Clinical Problem	Well-Established Treatment(s)
Autism Spectrum Disorder (ASD) *Deficits in communication, impaired social relationships, repetitive behaviors, and unusual preoccupations and interests. Conceptualized as a spectrum because some individuals function relatively well and others show severe impairments.*	Applied Behavior Analysis
Attention-Deficit Hyperactivity Disorder (ADHD) *Impulsivity, inattentiveness, or both, that are significantly greater than other children of the same age; unusually low self-control over behavior and emotions.*	Behavioral Classroom Management Behavioral Peer Interventions Behavioral Parent Training
Oppositional Defiant Disorder (ODD) *Age-inappropriate levels of anger, opposition, and defiance toward a parent, caregiver, or teacher, including by arguing, talking back, breaking rules, and deliberately annoying others.*	Behavioral Parent Training
Conduct Disorder (CD) *Aggression (including bullying and sexual assault), cruelty to people or animals, fire-setting and other destructiveness, disobedience, and truancy.*	Behavioral Parent Training
Depression *Weeks of sadness, lethargy, disturbed sleeping and eating, suicidal thoughts, and*	Cognitive Therapy Cognitive Behavior Therapy Interpersonal

impairment in social and educational settings. Younger children may show temper tantrums and irritability rather than sadness, and may lose interest in previously enjoyable things.	Therapy
Anxiety and anxiety-related disorders *Displayed as specific fears (such as of animals or strangers, losing a parent, school shootings, or being kidnapped), unfocused anxiousness, and posttraumatic stress disorder.*	Cognitive Therapy Cognitive Behavior Therapy

Source: Based on data from http://effectivechildtherapy.com/

As shown in the table, operant conditioning and other behavior modification methods described in Chapter 9 (applied behavior analysis, behavioral classroom management, behavioral parent training, behavioral peer interventions) tend to be most efficacious for ASD, ADHD, and ODD/CD. What these interventions have in common is that a clinician, parent, teacher, or other adult in the child's life changes environmental contingencies so as to encourage desirable behaviors and reduce undesirable ones. Even in behavioral peer interventions for ADHD, an adult guides the peers to provide rewards for appropriate behavior. In behavioral classroom management and behavioral parent training, the therapist may not necessarily meet with the child because the focus of treatment is on training parents or teachers to set up and manage the reward contingencies.

For depression and anxiety, however, cognitive, cognitive behavior, and interpersonal therapy approaches tend to be most efficacious. What these

interventions have in common is that the therapist is working directly with the child client to help the child change the beliefs, relationship dynamics, and behavior patterns that are sustaining the child's problems. Many of these techniques are similar to those used with adults who are anxious and/or depressed. So the therapist might help a child address his social anxiety by re-entering social situations he has been avoiding and challenging his belief that other kids are going to laugh at him if he speaks up in class. And using a technique called **activity scheduling**, a depressed adolescent might be encouraged to engage in a greater number of enjoyable activities in her life that give her a sense of mastery or pleasure.

Activity scheduling
A cognitive behavior therapy method that encourages depressed clients to increase the number of enjoyable activities in their lives.

Why do contingency management methods work best for some disorders whereas cognitive/interpersonal methods work best for others? It may be that —compared with those who are anxious or depressed—children displaying ASD, ADHD, and ODD/CD tend to be younger, less aware of how problematic their behavior is, and less motivated to try to change it. Further, even if maladaptive cognitions played a part in their problems, these children may not yet be mentally mature enough to address them by talking to a therapist. By contrast, older children and adolescents who experience depression and anxiety may be far more aware of their distress, more troubled

by their symptoms, and better able to work with a therapist to identify and change the thinking patterns that may be contributing to their problems.

The value of these two approaches can change over time and across clients. For example, as children become adolescents, it may no longer be necessary to address problems such as ADHD through contingency management alone. As their capacity for logical thinking and self-reflection grows, adolescents and emerging adults with ADHD can benefit from other forms of treatment, especially cognitive behavior therapy. Further, there are many cases in which children or adolescents display more than one disorder, each of which might benefit from a different treatment approach.

There has not yet been extensive research on the long-term effects of psychosocial treatments in children, but some trends are emerging. For example, treatment effects have been shown to persist for many years after cognitive behavior therapy for anxiety in older children (e.g., Kendall et al., 2004), but not after contingency management for ADHD in younger ones (Molina et al., 2009). The difference may lie in the nature of the two interventions. Cognitive and cognitive behavior therapy aspires to create a durable change in the way children interpret signals of threat, which presumably could persist over time, even after therapy is over. Contingency management for ADHD aspires to change the child’s environment in ways that support attentiveness and reduce disruptive behaviors. The effects of these changes may only last as long as the contingencies are in place. The challenge now is to find ways to teach these children self-control skills that will persist over time and outside of the therapeutic context (see Evans et al., 2018).

As is true with adult therapy, there is intense interest in disseminating treatment research findings to clinicians in the community and in helping

them implement the treatments (Southam-Gerow et al., 2012). These dissemination efforts are aided by the Society of Clinical Child and Adolescent Psychology (Division 53 of APA), whose website lists evidence-based treatments and also provides free training sessions for practitioners.

Pharmacological Interventions

Many child and adolescent clients are treated with prescription drugs in addition to, or instead of, psychotherapy. For example, stimulant drugs such as methylphenidate (Ritalin, Concerta, Metadate) and amphetamine (Adderall, Dexedrine, Vyvanse) preparations are prescribed routinely for ADHD. Well-conducted studies have shown that stimulant medication reduces the inattention and especially the hyperactive/impulsive behavior of these children (Nigg, 2013). The children tend to remain seated longer, finish more academic work, give correct answers more often, and show improved social interactions with peers, parents, and teachers. In the United States, most stimulant medications are approved by the Food and Drug Administration for children ages 6 and older, though some are approved for children as young as age 3.

In addition, selective serotonin reuptake inhibitors (SSRIs) are prescribed to treat depression and anxiety disorders in children and adolescents. Fluoxetine (Prozac), fluvoxamine (Luvox), and sertraline (Zoloft) are among the most commonly used. In the United States, SSRIs are approved for use with children around age 8, but some may be prescribed for children as young as 6.

Thinking Scientifically Do the Risks of Medication for Child and Adolescent Disorders Outweigh Their Benefits?

Advocates of pharmacological treatments for child and adolescent disorders focus on research supporting the benefits of these

treatments (e.g., Walkup, 2017). Some children taking SSRIs, for example, report feeling as though a heavy weight has been lifted off their shoulders, that they are better able to face the challenges of schoolwork and peer interactions, and that they feel more hopeful about the future. Nevertheless, surveys and meta-analyses of the overall effects of psychoactive drugs show that they may work only a little better than placebo pills, and often no better than either placebos or psychosocial treatments. Further, the side effects of these drugs can be unpleasant enough that many clients stop taking them (e.g., Cipriani et al., 2016; Locher et al., 2017), So, as is the case with adults, controversy surrounds the use of medication for the treatment of young people's psychological and behavioral problems.

What am I being asked to believe?

Psychiatrist Peter Breggin is one of the strongest critics of prescribing drugs for children's emotional or behavioral problems. He has summarized his position in books such as *Talking Back to Ritalin: What Doctors Aren't Telling You about Stimulants for Children* (2001), and *The War against Children: How the Drugs, Programs, and Theories of the Psychiatric Establishment Are Threatening America's Children with a Medical "Cure" for Violence* (Breggin & Breggin, 1994). Of particular concern to Breggin is what he sees as the overuse of medication for behaviors that are not necessarily abnormal or that are only abnormal in particular cultures. He fears that we are trying to medicate the childhood out of children.

What kind of evidence is available to support the claim?

The most common side effects of medications for ADHD include loss of appetite or difficulty sleeping, whereas headache and drowsiness are the most common side effects of SSRIs. Rarely, there are more serious side effects of both kinds of medication, including potentially fatal cardiovascular problems; as you might expect, this risk is greater among children with a history of heart problems. There is also evidence that in rare cases, there may be a slightly increased risk of suicidal thoughts or actions while taking some SSRIs (Locher et al., 2017).

Are there alternative ways to interpret the evidence, including those that my biases and preconceptions might have kept me from seeing?

The potential negative side effects of medications for children's psychological disorders leads many parents and clinicians to prefer behavior modification and/or cognitive behavior therapy treatments instead. However, advocates of drug treatment argue that psychosocial treatments are not risk-free (Barkley, 2018). In addition to the time and money that is lost when psychosocial treatments fail, children known to be in treatment can be stigmatized by peers, and even teachers, possibly leaving them feeling as though "there must be something wrong with me." (Of course, this same risk may exist if a peer learns a child is taking medication for a mental health problem.) Also, when groups of children receive psychosocial treatment in groups, there is the risk of **deviancy training**, a process in which the children reward one another's problematic behavior and thus strengthen it.

In other words, parents must consider the risks of psychosocial treatment just as carefully as they do those of medication.

Deviancy training
A process through which children in group treatment reward one another's' problematic behavior.

What additional evidence would help to evaluate the alternatives?
Parents evaluating the pros and cons of medication and psychosocial treatment must keep one thing in mind: either option is likely to be more beneficial than doing nothing. There are clear risks associated with allowing childhood and adolescent disorders to go untreated. For some children, the continuing impact of these disorders can contribute to a lifetime of suffering involving conflict with parents, teachers, and peers, academic failure and dropout, criminal activity, and even more severe forms of disorder in adulthood (Cassel & Bernstein, 2007; Copeland et al., 2015; Molina et al., 2009).

As the late psychotherapy researcher Gordon Paul (1969) pointed out decades ago, what we still need to know about treating childhood, adolescent (and adult) disorders, is which forms of treatment, conducted by which therapists, are most effective for which clients, with which problems, under what circumstances, and how do they work? We discuss the progress of this kind of research in detail in Chapter 7.

What conclusions are most reasonable given the kind of evidence available?

All in all, the question of whether to use psychoactive medications with children and adolescents is unlikely to be answered with a simple yes or no. As with adults, every case of child or adolescent disorder is different, meaning that clinical child psychologists and the medical professionals with whom they consult must decide what is best for each client. If these mental health professionals are clinical scientists, their decisions will be *evidence based*. As described in Chapter 1, this means that they will base their decisions on the best available research about empirically supported treatments, in conjunction with their clinical experience and expertise, and the cultural and personal values, preferences, and needs of clients and their families. Doing so will ideally maximize the effectiveness of treatment and minimize the risks of negative side effects.

A Case Example

In working with the Jackson family, Dr. Leon became aware that in addition to their other concerns, parents Lena and James are at a loss about how to handle the troublesome behavior of Rachel's 10-year-old brother, Jamal. They report great difficulty in getting Jamal to wake up on time, get ready to leave for school, and do his homework and household chores. He needs constant reminders about these tasks, and if his parents do not stay with him, he will usually stop what he is supposed to be doing and start playing video games. Homework is a particular struggle. It takes several hours longer than is typical for children his age, and generates daily yelling matches with his parents. Given all their other family problems, Lena and James are being seriously worn down by Jamal's behavior. Sometimes, they are just too tired and stressed out to bother trying to keep Jamal on track.

Jamal's teacher suspects that he might have ADHD and, as described in Chapter 5, he was given intelligence and other tests by Dr. Leon. The results suggested that Jamal's inattentiveness at school was not severe enough to qualify for an ADHD diagnosis, but Dr. Leon concludes that there are still things that can be done to manage his behavior at home that—to his parents, at least—certainly have the impact of ADHD and ODD. Specifically, she recommends a 1-day behavioral parent-training workshop offered at a nearby community center by Amir Abadi (not his real name), a counselor who works for an advocacy group called Children and Adults with ADHD (see www.chadd.org).

At the workshop, Lena and James meet other parents who are dealing with child behavior problems like Jamal's. They feel some immediate relief

just to realize they are not alone in their struggles and that they need not feel stigmatized by them. Mr. Abadi begins the session by sharing some ideas for building a more positive parent–child relationship. The idea is that an improved parent–child relationship will help Jamal be more receptive to his parents' guidance and wishes. Mr. Abadi suggests that a first step toward bettering the relationship is for parents to plan enjoyable activities with their children, during which they make it clear that they are interested in their children's lives.

Next, Mr. Abadi asks the parents to think about what expectations they have for their children's behavior, and then to clearly tell the children exactly what they expect. Lena and James react to this task by saying that "We do this all the time! Jamal should already know what we want him to do!" Mr. Abadi explains that, whereas typically developing children may not need constant reminders, they are helpful and even necessary for children whose behavior suggests ODD and ADHD. But it takes more than reminders, he says, so he teaches Lena and James how to set up a contingency program in which they provide reinforcements whenever Jamal displays desirable behaviors (e.g., taking out the trash), and, when appropriate, to take away privileges when he does not. They focus especially on a behavioral contingency plan at homework time, and decide that, for every 10 minutes that he concentrates on this homework, Jamal will earn one minute of video game time that can be redeemed later. They learn to be consistent in implementing this plan even if Jamal whines or gets angry.

The plan does not work perfectly all the time, but at least Lena and James feel somewhat more in control of Jamal's behavior and of their own stressors. Their relationship with Jamal improves as a result of sharing some fun activities, and of calmly telling Jamal about the behavior they expect to

see. Once Jamal realizes that his parents are truly interested in him, and experiences clear and consistent expectations about his behavior, it becomes easier for him to follow directions, thus providing more opportunities for them to reward him.

Prevention of Childhood Disorders

In addition to research on how best to treat disorders of childhood and adolescence, clinical child psychologists have also engaged in efforts to prevent these disorders from appearing in the first place (Institute of Medicine, 2009). Examples of effective prevention strategies include:

- Improving parent–child attachment in order to prevent a myriad of emotional/behavioral problems (Van Zeijl et al., 2006).
- Using a television series to teach parents about positive parenting skills in order to increase children's compliance and decrease their aggressiveness (Sanders & Murphy-Brennan, 2017).
- Using cognitive behavior techniques to decrease the likelihood of anxiety problems in children (Barrett et al., 2006).
- Educating parents and adolescents about interpersonal skills and cognitive strategies that can head off depression (Shochet et al., 2001).
- Strengthening communication and parental monitoring in African American families to prevent adolescents from engaging in risky behaviors, such as drinking alcohol, using illicit drugs, and having unprotected sex (Brody et al., 2006).
- Large-scale anti-bullying programs that help students learn about the problem, develop more empathy for others, and develop strategies to help victims of bullying (Karna et al., 2011).

- Providing additional resources and extensive services to impoverished families and communities in order to prevent a whole host of emotional/behavioral problems in children and adolescents (Brotman et al., 2003).

It is important to recognize that not all prevention strategies work. One of the most widely used disorder prevention efforts is called the Drug Abuse Resistance Education (DARE) program. Typically presented by local law enforcement agencies, it is offered in all 50 U.S. states and in some international locations, too. The goal of DARE is to demonstrate the negative consequences of alcohol and drug abuse (West & O'Neal, 2004). Unfortunately, a number of well-controlled, long-term studies have shown that the DARE program is not effective in changing attitudes toward drugs and alcohol, in preventing their use, or in promoting self-esteem (e.g., West & O'Neal, 2004).

Another more promising line of prevention-oriented research is related to the *positive psychology* movement mentioned in Chapter 3 (Duckworth, Steen, & Seligman, 2005). Specifically, many clinical child psychologists are interested in finding ways to increase **resilience** in children, that is, in finding ways to increase protective factors so as to decrease the likelihood of developing emotional/behavioral problems in children at risk for those problems (Masten, 2018; Yoshikawa, Aber, & Beardslee, 2012).

In Review Treatment and Prevention of Child and Adolescent Disorders

Common Child and Adolescent Disorders	**Empirically Supported Treatment Methods**
Anxiety disorders Depression Attention-deficit hyperactivity disorder (ADHD) Autism spectrum disorders (ASD) Conduct disorder (CD) Oppositional defiant disorder (ODD)	For ADHD, ODD, CD, and ASD: Behavior modification (e.g., contingency management by parents, teachers, and peers). For anxiety and depression: Cognitive therapy, cognitive behavior therapy, interpersonal therapy.
Pharmacological Treatments For ADHD: stimulants and amphetamines For anxiety and depression: SSRIs and antidepressants	**Advantages and Disadvantages** + Easy to administer; work reasonably well; other children need not know drugs are being used. − Negative side effects, sometimes serious enough to cause harm or discontinuation of treatment; may not work better than placebos or psychosocial treatments. − Important to consider latest evidence given results for effectiveness may differ considerably based on disorder (e.g., ADHD vs. depression), age of child or adolescent, and particular medication.
Prevention of	**Examples**

childhood disorders Aimed at reducing the need for treatment	Building parent–child bonds; teaching positive parenting skills; teaching interpersonal and cognitive skills to prevent depression; anti-bullying programs.

Test Yourself

1. The benefits of treatment for _________ tend to last longer than those of treatment for ________.

2. Cognitive and cognitive behavior therapies are most commonly used with _____ children whose problems are related to _______ and/or _______.

3. When children in group treatments for a disorder reinforce each other's problematic behavior, the process is called __________.

You can find the answers in the Answer Key at the end of the book.

Resilience

A characteristic or set of characteristics seen in some children that acts as a protective factor against the development of emotional and behavioral problems in the face of stressors.

The Future of Clinical Child Psychology

Section Preview In this section, we highlight four factors that are particularly relevant for the future of clinical child psychology: diversity and multiculturalism; increasing access to mental health care; the rise of interdisciplinary research and practice; and the role that technology plays in the mental health of children and adolescents.

Although advances in clinical child psychology have lagged several decades behind developments in adult clinical psychology, the child field is catching up rapidly. In addition to the trends that we have mentioned elsewhere in relation to clinical psychology in general (e.g., increasing focus on evidence-based assessment and treatment, dissemination of treatments that work so that they can be implemented in the community), a number of other trends are likely to characterize the future of clinical child psychology.

Diversity and Multiculturalism

Diversity in race, ethnicity, culture, and family composition has increased every decade in the United States, and these demographic trends are projected to continue. The characteristics of people under 18 are even more diverse than they are for adults, making the topic of diversity and multiculturalism especially relevant for clinical child psychology (Pew Research Center, 2019). As we mention in Chapter 1, there is a great deal of interest in promoting culturally competent practices in clinical psychology, and in clinical child psychology—both in the United States and around the world (Huey & Polo, 2017; Rescorla et al., 2011).

This goal is important because many of the traditional psychological treatments that were developed mainly for majority populations tend to be less effective for youth from single-parent homes and disadvantaged and ethnic minority backgrounds (Huey & Polo, 2017). Therefore, researchers in clinical child psychology are seeking to tailor psychological treatments in ways that make them more relevant for youth and families from a wider variety of backgrounds (Yasui & Dishion, 2007). For example, the Familias Unidas program is a family-centered, ecologically and developmentally relevant intervention that works to reduce emotional and behavioral problems in Hispanic/Latino/Latina adolescents (Coatsworth, Pantin, & Szapocznik, 2002). Other efforts have included therapist training in culturally competent practices, altering therapy content to be more culturally sensitive, and matching therapists and clients on culturally meaningful variables (Huey & Polo, 2017).

However, when the outcomes of culturally enhanced evidence-based treatments are compared with those of standard evidence-based treatments for children and adolescents, few differences have emerged (e.g., Huey & Polo, 2017). These findings are surprising because they are in contrast to the effects of culturally adapted treatments for adults, which are typically more effective than standard versions, at least for some subgroups of clients (Castro, Barrera, & Steiker, 2010). Thus, there is still work to be done to make evidence-based treatments even more helpful for culturally diverse youth.

Clinical child psychologists are also increasingly interested in the similarities and differences that appear among children and adolescents in various countries around the world. For example, the ASEBA behavior rating scales we mentioned earlier have been translated into 74 languages and have been used for research in 67 different cultures, resulting in over 6,000 publications (Rescorla et al., 2007). These studies have revealed more similarities than differences in the psychological functioning and psychological problems of children and adolescents around the globe (Rescorla et al., 2011) (See Figure 11.3). Unlike the patterns that are relatively well understood with adult populations, clinical child psychologists still need to ascertain which specific variables influence effective treatment of children from different cultures.

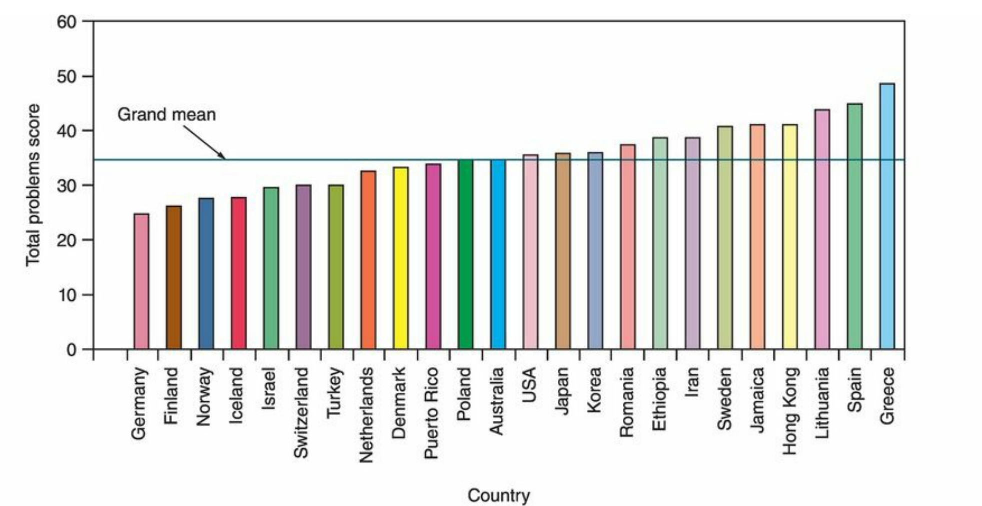


Figure 11.3 Youth Self-Report Total Problems Scores in 24 Countries (*N* = 27,206)

Perhaps the commonalities seen in these data will help clinical child psychologists to better understand the consistency seen in the results of evidence-based treatments across different multicultural groups of youngsters within the United States.

(Source: Rescorla, L., Achenbach, T. M., Ivanova, M. Y., Dumenci, L., Almqvist, F., et al. (2007). Epidemiological comparisons of problems and positive qualities reported by adolescents in 24 countries. *Journal of Consulting and Clinical Psychology*, *75*, 351–358.)

Access to Care

As many as 25% of children and adolescents who meet criteria for a psychiatric disorder have never had access to outpatient mental health services (Jensen et al., 2011; Storch & Crisp, 2004). This pattern is particularly true for youth from racial/ethnic minority groups and from impoverished backgrounds (Huey & Polo, 2017). For example, compared with European American parents, African American parents report experiencing greater barriers to accessing mental health for themselves and/or their children (Thurston & Phares, 2008). Within the Hispanic/Latino/Latina community, unmet need for services appears to be due to a variety of factors, including failure to recognize psychological symptoms, the perception of a stigma associated with seeking mental health services (Chavez et al., 2010), and lack of access to providers with the relevant language or cultural competency training (see Chapter 15).

Although we do not yet fully understand all the factors underlying the disparity in service access between minority and majority groups, clinical child psychologists are becoming increasingly involved in efforts to make high-quality mental health-care services more available to everyone. As with adults, however, these efforts will be complicated by features of the health-care system and disparities in health-care funding across the United States. One step in the right direction appears to be the delivery of evidence-based treatment programs in schools (e.g., Adelman & Taylor, 2012). These programs make it possible for young clients to be treated on a regular basis without the need to rely on parents to make appointments and transport the children to therapy sessions. Unfortunately, though, when therapy is

delivered at school, it may be more difficult to draw parents into the treatment process (Adelman & Taylor, 2012). Thus, alternative methods to improve service delivery are still being sought (see our discussion of mental health-care delivery models in Chapter 10).

Interdisciplinary Approaches to Research and Practice

As in clinical psychology generally, the field of clinical child psychology is moving toward an increasingly interdisciplinary view of children's functioning, with special attention being paid to the many interconnections among biological/genetic, cognitive, social, behavioral, and environmental influences on children (e.g., Moffitt, 2017). As discussed in Chapter 2, the Research Domain Criteria (RDoC) initiative has advanced efforts to identify potential common causes of disorders within the neurodevelopmental arena, such as genetic and epigenetic influences (Beauchaine, Gatzke-Koop, & Gizer, 2017), behavioral inhibition (Kagan, 2017), and emotional dysregulation (Cole, Hall, & Hajal, 2017). Progress in these efforts will depend on cooperation among scientists from various disciplines, including, of course, clinical psychologists.

The cooperation of professionals from many disciplines will also be important in improving the success of treatment and prevention programs for child and adolescent disorders. So clinical child psychologists will increasingly find themselves working on interdisciplinary teams whose members include teachers, pediatricians, social workers, guidance counselors, child psychiatrists, and psychiatric nurses (Kazak et al., 2010). In fact, increasing efforts are being made to integrate behavioral health services (such as therapy for mental health problems) into primary care settings, including pediatricians' offices (Vogel et al., 2012). Known as *integrated primary care*, offering mental health services in a primary care setting is thought to improve children's and adolescents' access to the mental health services that they need.

Technology and Youth Mental Health

Technology has dramatically changed the lives of children and adolescents over the last three decades. Surveys suggest that 95% of adolescents between 12 and 17 have access to a smartphone, and 45% report being online "almost constantly" while another 44% report being online "several times per day" (Pew Internet and American Life Project, 2018). YouTube, Instagram, Snapchat, and Facebook, in that order, are the most popular platforms for more than half of adolescents.

What are the effects of all this technology, and how might it relate to the problems seen in the clients of clinical child psychologists? What we know so far suggests a mixed picture. On the positive side, many if not most adolescents say they use technology to help them stay connected to, or deepen a relationship with, people who they also know in face-to-face contexts (Nesi, Choukas-Bradley, & Prinstein, 2018a, b). Further, many adolescents have positive, mutually supportive, and affirming interactions online in much the same way as they do in person. These positive online interactions have been shown to help young people adjust to life transitions and other stressors, such as beginning a college career (Mikami et al., 2019).

For young people with psychological disorders, however, online interactions are more likely to be of poor quality, less positive and affirming, and more likely to lead to what some researchers have called "internet addiction," although it is not certain whether compulsive internet use is a true addiction (Griffiths, 2018). This should not be surprising, because these adolescents are the ones who are most likely to also have difficulty with in-person interactions. In other words, for them, the online context may simply

be another arena in which the symptoms of their disorders appear (Nesi et al., 2018a, b). Further, these young people may be more vulnerable to the negative effects of poor online interactions and patterns of internet use (Mikami et al., 2019). For example, around 23% of adolescents report having experienced cyberbullying (Hamm et al., 2015). This fact is worrying because of the potential negative effects of cyberbullying, which can range from anxiety and depression to suicide (Zych, Ortega-Ruiz, & Del Rey, 2015).

As a partial counterbalance to the internet's dangers for young people with psychological disorders, there is technology designed to help them receive needed treatment (Cuijpers et al., 2017). Many troubled adolescents want help, but fear what they see as a stigma associated with seeking treatment. The internet can help them overcome this barrier by helping these young people find others who are experiencing the same problem and thus feel less alone. It can have the same beneficial effect for the parents of children and adolescents who need help. As we describe in Chapter 10, technology can also be used to provide treatment. For example, there are online evidence-based treatments designed for children and adolescents with anxiety disorders (Khanna & Kendall, 2010; Spence et al., 2011), computer-based attention training programs for inattentive first-graders (Rabiner et al., 2010), and coaching of parenting skills via live videoconferencing (Wade Oberjohn et al., 2011). These and other technological advances will no doubt continue in the future (Cuijpers et al., 2017).

Clinical Geropsychology

Section Preview This section describes the development of clinical geropsychology as a specialized field of research and practice, and highlights demographic trends that demand increased professional attention to the psychological needs of older adults.

Rachel Jackson's grandmother, Danutė Bagdonas, has enjoyed living near her daughter and son-in-law, Lena and James, and serving as part-time babysitter as her three grandchildren grew up. She remains fiercely proud and independent at age 70, but some physical and cognitive changes have begun to challenge her ability to continue living alone in her small, two-story house. For one thing, arthritis in her hips and knees has made walking painful, especially when climbing stairs. In addition, as we describe in Chapter 3, Rachel's mother, Lena, has noticed that Danutė's memory is not as good as it used to be, that she sometimes seems confused, and more withdrawn than usual.

At the suggestion of Dr. Gloria Leon, the clinical psychologist whom Lena had consulted about Rachel's problems, Danutė was evaluated by a clinical neuropsychologist (see Chapter 13 for details), but Dr. Leon also recommended that Mrs. Bagdonas see a **geropsychologist**, a clinical psychologist specially trained to conduct assessment and treatment with older adults. Geropsychologists understand that older adults' long lives create unique characteristics and needs, including broad perspectives and experiences, rich and complex personal and family histories, and the emergence of special medical, psychological, and social challenges.

Geropsychologist

A clinical psychologist who is specially trained to conduct assessment and treatment with older adults.

Family Matters

As in younger clients, the mental health problems of older adults can create ripple effects in the rest of the family. So the geropsychologist who sees Danutė for individual sessions will likely want to bring Lena, James, and the grandchildren into the picture as well.

(Source: Anshul Mathur/EyeEm/Getty Images.)

A Brief History of Clinical Geropsychology

The average American's longevity has increased by 30 years between 1900 and 1999, with similar changes found in other developed countries (Centers for Disease Control, 1999). By 2017, life expectancy in the United States was approximately 76 years for men and 81 years for women (Murphy et al., 2018). More adults than ever before survive into old age, and as of 2018 there were an estimated 52 million Americans over age 65—roughly 15% of the population (U.S. Census Bureau, 2017). All indications are that the growth of the older adult population will continue. By 2035, more than 65 million Americans will be over the age of 65, and 7 million of them will be 85 or older (U.S. Census Bureau, 2018). Indeed, the fastest-growing age group in the United States (as a proportion of the population) is made up of centenarians, people who are 100 or older (Xu, 2016). By 2035, adults over 65 will outnumber those under 18, and by 2060, older adults in the United States will constitute one-quarter of the population (U.S. Census Bureau, 2018). These older adults will mirror the general population in terms of their racial, ethnic, and cultural diversity (U.S. Census Bureau, 2018). They may also reflect current disparities in longevity, health, and well-being based on income and location of residence; wealthy and urban Americans will probably live between five and 10 years longer than those who are poor or live in rural areas (Singh & Siahpush, 2013).

Clinical Psychology Discovers Older Adults. Late life is a period of continuing adaptation and personal growth, but the field of clinical psychology initially showed little formal interest in old age. This was partly because early developmental and psychoanalytic theories were concerned

primarily with the early stages of life, viewing them as the key generative period that paved the way for adulthood. Once maturity had been achieved, development was assumed to be complete, with little or no meaningful changes occurring between early adulthood and the end of life. Similarly, though clinicians recognized the existence of mental health problems in older people, such problems were regarded mainly as continuations of disorders rooted in childhood.

It was not until clinical psychology began to grow and diversify into the specialty areas described in Chapter 2 that clinicians began to think of late adulthood as more than a postscript to early development. The first influential proponent of this view was developmental psychologist and psychoanalyst Erik Erikson. Erikson regarded life as a constant process of psychological development and argued that changes in later life were just as critical as those in childhood, even though they occurred less rapidly (Erikson, 1959; Erikson & Erikson, 1998). Erikson expanded the psychoanalytic model of developmental conflict to cover the entire life span. He saw late middle age, and especially old age, as critical capstone stages during which life experiences and circumstances helped or hindered people's ability to remain productive, engaged, and satisfied with their lives (Erikson & Erikson, 1998). Erikson's wife, developmental psychologist Joan Erikson, referred to this final stage as *gerotranscendence*, in which development continues in the context of physical decline and dependency (Erikson & Erikson, 1998).

Some geropsychology researchers have raised doubts about the utility of stage-based models, viewing development as a gradual shift in personality features rather than a series of conflicts (Debast et al., 2014; Griffen, Mrozcek, & Wesbecher, 2015). By doing so, these researchers have touched off an ongoing debate in geropsychology: to what extent are the features of

late life truly the product of age rather than of changing life circumstances? A definitive answer remains elusive, but researchers have nonetheless documented several ways in which older adults cope with and adapt to the unique challenges that arise as they age. As we describe below, stage-based models that overemphasize decline among older adults fail to recognize the many examples of healthy aging in the population, and the many ways in which older adults adjust their goals and behavior to continue thriving.

Mental Health in Old Age. Researchers have found that, contrary to popular belief, mental health actually improves over the course of most people's lives. In general, middle-aged adults show stable or increasing levels of satisfaction, contentment, and emotional stability compared to younger adults, and this positive trend continues through much of late life (Griffen, Mrozcek, & Wesbecher, 2015). Older adults report lower rates of mental distress, lower levels of worry, and increased life satisfaction compared to younger adults (Centers for Disease Control, 2013a, b; Karel, Gatz, & Smyer, 2012). The incidence of psychopathology also tends to decline in the older adult population (Scheibe & Carstensen, 2010). Across their life course, many older adults cultivate, practice, and strengthen coping tactics, such as finding purpose and meaning, establishing a high quality (rather than high quantity) social network, adapting to and accepting late-life changes and challenges, and finding religion and spirituality as enhancing their well-being (Aldwin & Igarashi, 2015). Older adults often also show gains in emotion regulation and emotion-linked problem solving (Gurera & Isaacowitz, 2019). For example, according to Socioemotional Selectivity Theory, as they recognize that their remaining time is limited, older adults choose to prioritize some life domains, such as close relationships, over others, such as competition (Barber et al., 2016; Carstensen et al., 1999). This selectivity

enables them to optimize performance in the prioritized domains by allocating more of their physical and socioemotional resources to those areas than to lower-priority areas (Freund & Baltes, 1998; Hess, 2014). The result of all these adjustments is referred to as **successful aging**, the maintenance of mental health, social engagement, and other protective factors in the face of age-driven change (Ellis & Velten, 1998).

Successful aging
An ability to maintain physical, psychological, and social health in the context of usual age-related changes.

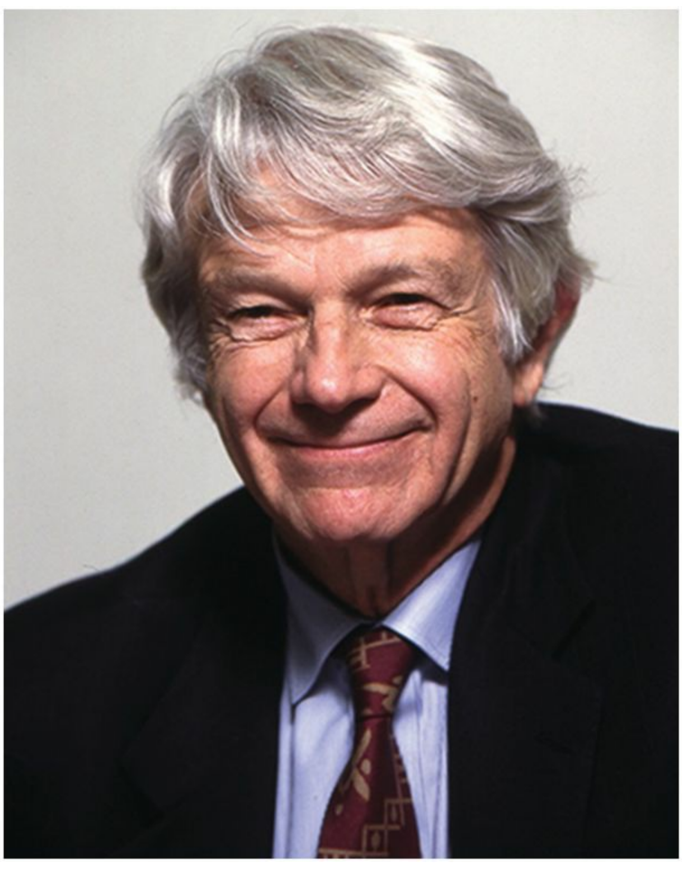
Research by Dr. Laura Carstensen, professor of psychology and director of Stanford University's Center on Longevity, has greatly advanced our understanding of how older adults shift life priorities as they age so as to optimize their emotional and interpersonal health.

The strength and resiliency associated with successful aging can be harnessed by geropsychologists as they work with older adults who do experience mental health problems. One in five Americans over the age of 55 has one or more diagnosable anxiety, mood, or cognitive disorders (Everett, 2019; Institute of Medicine, 2012; Karel, Gatz, & Smyer, 2012), and this figure does not include older people who have subthreshold symptoms that don't merit a full diagnosis but are still clinically significant (Blazer, 2003).

What puts some older adults at risk for developing psychological problems? As in Danutė Bagdonas's case, a major contributing factor is physical debility. Older people are more likely to suffer from health problems that limit mobility and functioning, cause chronic pain, and otherwise interfere with their capacity to lead what they perceive as fulfilling lives. Many older people are able to adjust and compensate for such physical changes up to a point, but severe physical decline may overwhelm their psychological and material resources. When this occurs, older adults may become less able to make use of supports that previously bolstered their mental health, such as social engagement or taking part in valued roles in the family. Long-term medical care can also become a mental and financial strain, leaving some older adults feeling shame and guilt over placing a burden on those around them. When psychological resources are chronically drained by isolation, physical and mental decline, and grief, the result may be

hopelessness, despair and severe pathology, including an elevated risk for suicide (Ryan et al., 2015; Salive, 2013; Szanto et al., 2012).

The Study of Aging and the Growth of Geropsychology. The emergence and growth of geropsychology were based on developments in the study of aging, and no one did more to bring aging to the attention of psychology, psychiatry, and medicine than physician Robert N. Butler. His efforts, and those of like-minded colleagues, highlighted the need for comprehensive research into aging processes and led, in 1974, to the creation of the National Institute on Aging (NIA) as a division of the National Institutes of Health (Achenbaum, 2014). With Butler as its founding director, the NIA began to fund research and training programs, disseminate information about physical and mental health in late life, and advise federal departments on topics relevant to older adults.



Robert N. Butler (1927–2010)

His landmark study, *Human Aging*, was among the first to dispel the misconception that cognitive decline was an inevitable consequence of aging and to show that disease, not age alone, led to dementia (Birren et al., 1963). He was also the first to address the subject of discrimination against older people and coined the term *ageism* as a source of negative stereotypes about and discrimination against older adults (Butler, 1969; Wilkinson & Ferraro, 2002).

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Today, many professional organizations are advancing research and practice in geropsychology. For example, division 20 of the American Psychological Association is devoted to furthering the study of aging and adult development (https://www.apadivisions.org/division-20/). Similarly, the Society for Clinical Geropsychology (https://geropsychology.org/) promotes the academic and professional aspects of clinical geropsychology and advocates for the mental health of older adults. Other related organizations include the American Geriatrics Society (https://www.americangeriatrics.org/), the American Association of Geriatric Psychiatry (https://www.aagponline.org/), the Gerontological Society of America (https://www.geron.org/), and aging-related subdivisions within organizations such as the National Association of Social Workers, the American Occupational Therapy Association, and the American Physical Therapy Association.

These and other organizations publish scholarly journals that provide a forum for research that informs the clinical practice of geropsychology.

Among dozens of others, these journals include *Psychology and Aging*, the *Journals of Gerontology*, the *Journal of the American Geriatric Society*, and the *Journal of American Geriatric Psychiatry*.

The Need for More Geropsychologists

Partly as a result of all this interest in aging, mental health treatment has become more accessible to older adults in the United States. The Older Americans Act of 1965, which was renewed in 2016, established a network of comprehensive social support services for older Americans and their caregivers (Colello & Napili, 2018), and Medicare, the primary health insurance provider for Americans over age 65, expanded coverage in the late 1980s to include psychotherapy and other mental health services.

Clinical geropsychologists are in high demand to provide these services, but there are still not nearly enough of these professionals available. One reason is that the vast majority of graduate students in clinical psychology training programs receive little or no instruction in geropsychology (Zweig et al., 2005; Hinrichsen et al., 2018). Consequently, they remain unaware of the opportunities and satisfactions of working with older adults. Many of their professors—and health-care professionals in general—may believe that late life is a period of inevitable decline and deterioration, that older people are so stubborn, sickly, or rigid as to be beyond help, and that working with older adults is therefore difficult, thankless, and depressing (American Psychological Association, 2014; Frameworks Institute, 2015). In short, clinical students are not being encouraged to become geropsychologists, and there are not enough geropsychology training programs (described in the next section) to accommodate those who are interested in the field, let alone enough to graduate the numbers of geropsychologists that will be needed in the future.

The lack of professionals trained to work with older adults is not limited to psychology. There is also a shortage of social workers, nurses, dentists, pharmacists, speech therapists, rehabilitation therapists, geriatric psychiatrists, and geriatricians (medical doctors trained to work with older adults). The Department of Health and Human Services has predicted that by 2025, the United States may require more than double the number of geriatricians currently practicing, yet the field of geriatric medicine has actually shrunk relative to the population in recent decades (Petriceks, Olivas, & Srivastava, 2018). The only upside to this sad situation is that career opportunities will abound for psychologists interested in working with older adults, as an ever more graying population becomes the new reality.

In Review Clinical Geropsychology

Definition	Geropsychologists are clinical psychologists with specialized training in the assessment and treatment of older adults.
Demographic trends	People are living longer and the number of older people will continue to grow, becoming a higher proportion of the population in most countries around the world.
Growth trends in geropsychology	Clinical psychology didn't originally pay much attention to older adults; early life was seen as more important. Advent of the study of aging stimulated the growth of geropsychology as a field of research and practice. There is still a shortage of trained clinical geropsychologists and other health-care providers interested in older adults.
Professional organizations	Professional organizations across health-care disciplines advocate for late-life mental health. Scientific journals publish research on assessment and treatment with older adults.

Test Yourself

1. The fastest-growing age group, as a proportion of the population, is over the age of ________.

2. Prejudice against and stereotyping of older people is called _______.

3. When older people are able to maintain positive relationships and good mental health despite changing abilities, they are experiencing _______.

You can find the answers in the Answer Key at the end of the book.

Unique Characteristics of Clinical Geropsychology

Section Preview Here we review a number of characteristics unique to clinical geropsychology, including specialized training for work with older adults, distinctive practice settings, and an appreciation of aspects of aging that have an impact on clinical assessment and treatment activities.

Training in Geropsychology

As described in Chapters 2 and 15, most students in clinical psychology training programs take the same set of basic courses, and then begin to focus on coursework and practicum experiences related to their more specialized interests in clinical subfields such as health, child, forensic, or neuropsychology. Students interested in geropsychology might get some exposure to the field as part of their general training if their programs offer courses on aging and if they can find opportunities for practicum or internship experiences with older adults. If they want more extensive training in geropsychology, they can find it in one of 17 U.S. graduate programs that offer a geropsychology track recognized by the Council of Professional Geropsychology Training Programs (CoPGTP; http://copgtp.org/). These program tracks include aging-focused courses, research, clinical experiences, and leadership opportunities (Allen, Crowther, & Molinari, 2013), all dedicated to helping students understand the complexities of human development later in life and their implications for older people's mental health.

This specialized training is based on the *Pikes Peak Model* that emerged from a conference held in Pikes Peak, Colorado in 2006; it outlines the knowledge, attitudes, and skills that clinicians need to work competently with older adults (Knight et al., 2009). As mentioned earlier, the current and projected number of students graduating from these programs will not meet the demands of our quickly growing population of older adults, so the CoPGTP has also developed a set of competencies to help all psychologists,

regardless of their specialty area, understand the basics of working with older adults (Hinrichsen et al., 2018).

Like other clinical students, those who have completed doctoral training in geropsychology will complete a one-year internship and, if desired, a postdoctoral fellowship. Geropsychology graduates are particularly attracted to internship and fellowship settings that offer intensive training in geropsychology (Hinrichsen et al., 2010), but virtually all settings offer at least some opportunities to work with older adults. Afterward, like other clinicians, geropsychologists may apply for a state license in clinical psychology and, later, for an additional credential that signifies an even higher level of expertise in mental health and aging. Offered by the American Board of Geropsychology (ABGERO) and the American Board of Professional Psychology (ABPP), this board certification signifies to the public and other health-care professionals that the psychologist is an expert in geropsychology.

Work Settings for Geropsychologists

Older adults bring their mental health needs to a variety of places, so geropsychologists find themselves working in settings not normally associated with clinical psychology, and alongside professionals from a wider than usual range of other health-care disciplines (see Table 11.3).

Table 11.3 Typical Work Settings for Geropsychologists

Setting	Description
Primary Care	Doctors' offices and other places where older people receive their usual medical care. In these settings, geropsychologists work with the medical team to address mental health symptoms, encourage proper medication adherence, and promote behavioral and lifestyle changes (e.g., smoking cessation; improved diet and exercise).
Geriatric Clinics	Specialty clinics staffed by an integrated team of geriatric specialists (e.g., geriatric physician, pharmacist, social worker, geropsychologist).
Long-term Care	Nursing homes, rehabilitation centers, and inpatient behavioral health facilities for older people who are no longer able to live independently and require nursing care and assistance with activities of daily living (e.g., dressing, bathing, cooking, eating).
Assisted Living	Facilities where residents are more mobile and independent than those in long-term care facilities. They have their own apartment, with access to common spaces, meals, medical services, and social activities.
Home-based	Services delivered in a client's home that are designed to

Care	promote safety and mental and physical health, and to maintain and prolong independent living.
Palliative and Hospice Care	Services delivered in facilities for patients with serious, often terminal, illness. Focus is on managing psychological symptoms, clarifying goals of care, and helping patients prepare for worsening health or death.

The team-oriented aspects of the work settings listed in Table 11.3 are based on the fact that the mental health problems of older adults are often first identified by someone other than a geropsychologist, usually their primary care physician (Ayalon et al., 2010). In recent years, physical, mental, and behavioral health services are increasingly being offered to older adults within medical settings by *interprofessional teams* that include geropsychologists, physicians, nurses, social workers, occupational and physical therapists, speech therapists, pharmacists, and chaplains. These teams have been shown to be especially effective at addressing older adults' interrelated physical and mental health concerns (Arean & Gum, 2013; Marengoni et al., 2011), medication needs (Fried et al., 2014), and functional limitations (Hickman et al., 2015).

A Focus on Life-Span Development

Their specialized training leads geropsychologists to look at the psychological problems of older clients against the backdrop of a lifetime of development. Adopting this **life-span perspective** helps geropsychologists to understand the impact of key events in their older clients' lives, how their lives have unfolded, and how it has been affected by historical contexts (e.g., the Great Depression, World War II, the civil rights movement of the 1960s) and their birth cohort (e.g., traditionalists born 1900–1945; baby boomers born 1946–1964).

Life-span perspective
Geropsychologists' efforts to look at the psychological problems of older clients against the backdrop of a lifetime of development.

A person's birth cohort, for example, may influence belief systems, values, civic and social engagement, sense of agency, and perceptions of the world and of themselves (Spiro, 2007). These beliefs can play a role in the client's understanding of psychopathology and receptivity to seeking mental health services (Kessler, Kruse, & Wahl, 2014). Perhaps more than other clinicians, geropsychologists take particular care to investigate and integrate their clients' long personal history and the developmental stages, transitions, and milestones that accompany it as they plan and deliver clinical assessment and treatment services.

Their approach to clients of any age has been described as *bio-psycho-socio-spiritual*. It focuses on age-related changes in the *biomedical* realm (e.g., sensory systems, chronic health conditions), in *psychological* characteristics (e.g., cognitive functioning, time orientation), in the *social* world (e.g., retirement, relocation), and in *spirituality* (e.g., existential views of life's meaning as it draws to a close). This multifaceted and dynamic framework emphasizes: (a) high degree of interaction among physical health, mental health, social, and spiritual resources; (b) the distinction between typical aging and age-related disease and disability; and (c) the possibility for late-life resiliency versus pathology.

In Review Unique Characteristics of Clinical Geropsychology

Specialized training	Graduate schools, internships, and postdoctoral fellowships provide specialized training in working with older adults. The Pikes Peak Model outlines attitudes, knowledge, and skills psychologists working with older adults should have, but every clinical psychologist needs some basic understanding of aging.
Work settings	Geropsychologists see older adults in a wide range of settings, almost always in interprofessional teams of health-care providers from numerous disciplines.
Life-span focus	Their life-span perspective enables geropsychologists to understand their clients’ mental health problems within the context of their entire lives. For example, people from different birth cohorts or generations typically have different attitudes and beliefs that influence their responses to mental health care.
Bio-psycho-socio-spiritual approach	Geropsychologists take a holistic approach to helping older adults by paying attention to their medical, psychological, social, and spiritual needs.

Test Yourself

1. The framework that guides the training and professional development of geropsychologists is known as the _________.

2. When working with older adults, geropsychologists consider the person’s ______ in order to understand how historical events may influence current functioning and beliefs.

3. The ____________ framework fosters a holistic, multifaceted, and dynamic conceptualization of the older adult client.

You can find the answers in the Answer Key at the end of the book.

Clinical Assessment with Older Adults

Section Preview In this section we review some of the clinical assessment methods used with older adults, including interviews, self-report measures, and neuropsychological testing. We also discuss some factors—such as clients' chronic medical conditions and assessment instruments' age-related limitations on reliability and validity—that geropsychologists must take into consideration when conducting clinical assessments with older adults.

Many older adults have characteristics that affect the way that clinical assessments are performed. For example, people with impaired vision and/or hearing can have some difficulty participating in a clinical interview or filling out clinical scales or forms. To optimize participation, geropsychologists routinely ask about the degree of their clients' sensory deficits and depending on the answer, may want to make sure that the client (or the client's caregiver) remembers to bring needed glasses and/or hearing aids (with charged batteries) to the assessment session. They may also arrange to have test forms printed or displayed in large font, and to ensure that interviews can take place in a quiet setting, free from distractions.

When conducting assessments, geropsychologists must also keep in mind that about 80% of clients over the age of 65 will have at least one chronic health condition, such as diabetes, hypertension, or arthritis (National Council on Aging, 2018). Some of these health conditions produce symptoms that overlap with the symptoms of psychological disorders, making it challenging to determine the cause of a person's physical or emotional distress. For example, hypothyroidism can produce symptoms that look like

depression (Hage & Azar, 2012), and deficiencies in vitamin D and vitamin B12, can create depressed mood and reductions in cognitive ability (Anglin et al., 2013; Hunt, Harrington, & Robinson, 2014). At the same time, psychological disorders often create physical symptoms. Depression can be associated with insomnia or hypersomnia, and anxiety may be associated with cardiac and gastrointestinal symptoms.

Older adults may be especially likely to focus on their physical symptoms rather than their psychological ones (Brenes, 2006; Gallo, Anthony, & Muthén, 1994; Hybels, Landerman, & Blazer, 2011), so geropsychologists are particularly careful to obtain a detailed medical history in their assessments. They also collaborate closely with the client's medical providers to better understand the extent to which the client's psychological symptoms may stem from a physical rather than a psychiatric disorder.

The results of clinical assessment with older adults can also be affected by the medications they are taking. Approximately 90% of adults over the age of 65 take at least one prescription medication, and nearly 40% are taking more than five of them (Kantor et al., 2015). Some medications can lead to significant psychological symptoms in older adults, whose bodies may be especially sensitive to drugs and less efficient at metabolizing them. Additionally, the simultaneous use of multiple prescription medications increases the likelihood of adverse side effects through drug-drug interactions (Qato, Ozenberger, & Olfson, 2018). Therefore, having a complete picture of their clients' medications is an important part of geropsychologists' medical history-taking.

Assessment Methods with Older Adults

Like other clinical psychologists, geropsychologists use multiple assessment methods to better understand their older adult clients. These methods include clinical interviews (with clients and clients' families), self-report instruments (including tests of personality and psychopathology), neuropsychological tests, and review of medical records.

Clinical Interviews. Interviews with older adults provide opportunities to learn about the rich and varied history that has led them to where they are today, including the challenges and resources they have brought with them. Older adults have a longer and often more diverse background than that of younger clients, so there are more "chapters" for the geropsychologist to cover in clinical interviews. There are also some unique topics to explore, such as how a person is transitioning into retirement, dealing with the death of a spouse or partner, and coping with chronic medical conditions and the approaching end of life.

The quality of social support and caregiving provided by the client's family is another important assessment topic with older adults (AARP & National Alliance for Caregiving, 2015). Information about that support can come from interviews with clients as well as with clients' family members. Indeed, with some older adult clients, as with children, relatives can often provide useful information about a wide range of clinically relevant topics. Spouses, partners, adult children, and other caregivers can all offer their views of the nature, onset, and duration of the client's problems, and how those problems affect the client's daily functioning, including dressing, eating, bathing, shopping, and managing medications and finances. These

informant reports can corroborate the client's account or provide a clearer clinical picture, especially in the case of older adults with cognitive impairment who may lack insight into their symptoms. For example, it is likely to be family members, not impaired clients, who identify potential safety concerns such as repeatedly failing to turn off stovetop burners.

The geropsychologist can conduct interviews that are open-ended and informal or, especially when assessing psychological disorders, might choose structured and semistructured interviews such as the *Structured Clinical Interview for DSM-5* (SCID-5; First et al., 2015) and the *Anxiety and Related Disorders Interview Schedule for DSM-5* (ADIS-5; Brown & Barlow, 2014). These latter instruments are often used with older adults, although they have not yet been validated for this age group.

Whether interviewing clients or family members, geropsychologists remain alert to signs of hidden conflicts or mistreatment, because families are not always supportive and longstanding family clashes can sometimes impair older adults' mental health. Sadly, about 10 to 15% of older adults in the United States have endured mistreatment, including neglect, physical, sexual, psychological, or emotional abuse, and financial exploitation (Pillemer et al., 2016; Yon et al., 2017).

Self-Report Measures. Geropsychologists can gather objective data on their client's emotional functioning and symptom severity by administering self-report instruments that have been validated for use with older adults. These include the *Hospital Anxiety and Depression Scale* (Spinhoven et al., 1997) and the *Penn State Worry Questionnaire* (Beck, Stanley, & Zebb, 1995). There are also self-report instruments that were created specifically for older adults, such as the *Geriatric Depression Scale* (GDS; Sheikh & Yeasavage, 1986; Yeasavage et al., 1982) and the *Geriatric Anxiety Inventory*

(Pachana et al., 2007). These age-specific instruments are especially useful because older adults may experience and describe their symptoms differently than younger people do. For example, as mentioned earlier, depressed older adults are more likely to focus on somatic symptoms, such as insomnia and fatigue, rather than on emotional ones, such as sadness or despair (Gallo et al., 1994; Hybels et al., 2011).

To assess an older adult's functional status from the client's own point of view, geropsychologists or other health-care providers can administer checklists such as the *Katz Index of Independence in Activities of Daily Living* (Katz et al., 1970), the Lawton Instrumental Activities of Daily Living Scale (Lawton & Brody, 1969; see Table 11.4), or the *Adult Functional Adaptive Behavior Scale* (Spirrison & Pierce, 1992).

Table 11.4 Lawton Instrumental Activities of Daily Living Scale (IADL)

Patient Name:________________________ Date:______________
Patient ID #__________________________

Scoring: For each category, circle the item description that most closely resembles the client's highest functional level (either 0 or 1).

A. Ability to Use Telephone		E. Laundry	
1. Operates telephone on own	1	1. Does personal laundry	1
initiative looks up and dials		completely.	1
numbers, etc.	1	2. Launders small items-rinses	0
2. Dials a few well-known	1	stockings, etc.	
numbers.	0	3. All laundry must be done by	
3. Answers telephone but does		others.	
not dial.			
4. Does not use telephone at all.			

B. Shopping

1. Takes care of all shopping needs 1
independently. 0
2. Shops independently for 0
small purchases.
3. Needs to be accompanied on 0
any shopping trip.
4. Completely unable to shop.

C. Food Preparation

1. Plans, prepares and serves 1
adequate meals independently
2. Prepares adequate meals if 0
supplied with ingredients.
3. Heats, serves and prepares 0
meals, or prepares meals but
does not maintain adequate diet.
4. Needs to have meals prepared 0
and served.

D. Housekeeping

1. Maintains house alone or 1
with occasional assistance (e.g.
"heavy work domestic help"). 1

F. Mode of Transportation

1. Travels independently on 1
public transportation or drives
own car. 1
2. Arranges own travel via taxi,
but does not otherwise use 1
public transportation.
3. Travels on public 0
transportation when
accompanied by another. 0
4. Travel limited to taxi or
automobile with assistance of
another.
5. Does not travel at all.

G. Responsibility for Own Medications

1. Is responsible for taking 1
medication in correct dosages at
correct time. 0
2. Takes responsibility if
medication is prepared in 0
advance in separate dosage.
3. Is not capable of dispensing
own medication.

H. Ability to Handle Finances

1. Manages financial matters 1
independently (budgets, writes
checks, pays rent, bills, goes to

2. Performs light daily tasks such as dish washing, bed making.	1	bank), collects and keeps track of income.	1
3. Performs light daily tasks but cannot maintain acceptable level of cleanliness	1 0	2. Manages day-to-day purchases, but needs help with banking, major purchases, etc.	0
4. Needs help with all home maintenance tasks.		3. Incapable of handling money.	
5. Does not participate in any housekeeping tasks.			
Score		Score	

Total score___________________

A summary score ranges from 0 (low function, dependent) to 8 (high function, independent) for women and 0 through 5 for men to avoid potential gender bias.

Neuropsychological Assessment. Geropsychologists sometimes need to know about the level of their older clients' cognitive functioning. Having that information can help determine if, for example, a client's poor concentration and indecisiveness are symptoms of depression or signs of dementia. Details about cognitive functioning are also important when the goal of assessment is to advise caregivers, family members, or courts about the advisability of allowing an older adult to drive, live alone, or manage finances (see Chapter 14 for more on the legal aspects of such assessments).

The first step in such assessments is often to administer a brief screening instrument such as the *Montreal Cognitive Assessment* (Nasreddine et al., 2005) or the *Mini-Cog* (Borson et al., 2003). These instruments are not designed to guide definitive statements about a client's cognitive status;

instead they identify potential cognitive impairment and indicate whether a more comprehensive neuropsychological evaluation is warranted.

As described in detail in Chapter 13, a full neuropsychological assessment includes a battery of tests designed to assess a client's abilities across multiple cognitive domains (e.g., attention, memory, executive functioning, visuospatial abilities). Neuropsychological evaluations can help determine whether an older adult's symptoms are more likely due to cognitive decline or a psychological disorder. For example, when assessment reveals executive dysfunction, such as difficulties with self-control, mental flexibility, and problem-solving, the more probable cause is a neurodegenerative disease rather than a depressive disorder. Repeated neuropsychological evaluations can also help clarify diagnoses. For instance, depressed individuals may show cognitive improvements on neuropsychological tests after receiving medication or psychotherapy, whereas those with progressive dementia will likely display additional cognitive decline.

Whether conducting neuropsychological testing themselves, or consulting with a clinical neuropsychologist, geropsychologists must be aware that—as is the case with certain self-report instruments—some of the instruments in standard neuropsychological test batteries have not been validated with older adults. For example, the *Wechsler Adult Intelligence Scale, Fourth Edition* (Wechsler, 2008) and the *Rey Complex Figure Test and Recognition Trial* (Meyers & Meyers, 1995) were not administered to individuals over the age of 90 when they were being developed so there are no normative data for individuals in that age range.

Medical Records. Medical records help geropsychologists learn more about health conditions that may be contributing to psychological problems.

For example, reviewing medical records might reveal that an individual’s psychological symptoms began at the same time as a medical illness. Reviewing laboratory results might help account for a client’s emotional distress, which could be caused by high levels of a thyroid-stimulating hormone in the blood. And, of course, review of a client’s prescription medications can help determine if negative drug interactions or other adverse side effects of medication are affecting a client’s physical, emotional, and psychological status.

A Case Example

When Lena Jackson accompanied her mother, Danutė Bagdonas, to their first appointment with geropsychologist Dr. Eleanor Parker (not her real name), Dr. Parker spent some time talking with Danutė alone, then with Lena alone, and finally with the two of them together. Dr. Parker asked Mrs. Bagdonas if she has any problems with her hearing or vision, and confirmed that Danutė has her eyeglasses with her so she can read any written forms she might be asked to fill out. Mrs. Bagdonas has been tested by a neuropsychologist, but as this is her first experience of a more general clinical assessment, Dr. Parker explains the confidential nature of the session and that she will be relying on Danutė for information that can be of help with her problems. She also assures Mrs. Bagdonas that she can understand her somewhat broken English and encourages her to take her time in telling her story.

Dr. Parker then begins an interview in which she learns about Danutė's immigration from Lithuania at age 25, her husband's death from a heart attack while in a psychiatric hospital, and the physical and emotional challenges of supporting her daughters, Lena and Regina, by working as a hotel housekeeper on weekdays and cleaning houses on weekends. She hears that Mrs. Bagdonas lives alone, about 20 minutes from Lena, in the house that she and Adomas bought shortly after they immigrated, but that over the years, the neighborhood has changed, and many of her Eastern European neighbors have moved into nursing homes or passed away. Danutė says she still drives, but not at night, so her visits to her grandchildren have become less frequent. (Later, when talking with Lena, Dr. Parker learns that results of the neuropsychological testing described in Chapter 13 suggested that Mrs.

Bagdonas has some dementia and should not be driving or living alone.) Danutė says her years of hard work have left her with aches and pains that make it challenging to keep up her own house. Dr. Parker administers two of the checklists we mentioned earlier to better understand Danutė's ability to perform various activities of daily living, and Danutė acknowledges that these abilities have been declining.

Dr. Parker also asks both Danutė and Lena about Danutė's psychological symptoms, medical history, prescription drugs, alcohol use, and social and leisure activities, including her involvement in the local Catholic church. Based on this initial interview information, Dr. Parker asks Mrs. Bagdonas to respond to a series of questions from the Geriatric Depression Scale. Her score of 9 out of a possible 15 suggests the presence of moderate depression. When Dr. Parker seeks further information about Danutė's mood using portions of the Structured Clinical Interview for the DSM-5 (SCID-5), Danutė acknowledges that she has felt "down" most days for the last several months, feels tired but has trouble sleeping, is sometimes skipping meals because she is not hungry, and has lost interest in many of the activities she used to enjoy. At one point she says "I feel I'm just waiting to die. I don't want to be a burden to my family. Maybe I should just get out of the way." Not surprisingly, Dr. Parker suspects that in addition to dementia, Danutė may have a depressive disorder, but she encourages Lena to consult with Danutė's primary care physician to rule out medical factors contributing to her depressed mood, such as hypothyroidism, and her memory difficulties, such as a vitamin B12 deficiency.

In Review Clinical Assessment with Older Adults

<table>
<tr><td>Unique elements</td><td>Need to accommodate age-related sensory deficits.
When considering diagnoses, need to rule out age-related medical illness, medication side effects, and expected age-related changes.</td></tr>
<tr><td>Assessment methods</td><td>Standard and age-specialized clinical interviews, self-report, and neuropsychological measures, family reports, review of medical records.
Need to recognize that some instruments have not been validated with older adults, and to use caution in interpreting scores.</td></tr>
<tr><td colspan="2">Test Yourself
1. Older adults with depression may be more likely to focus on _________ symptoms and less likely to report _______ symptoms.
2. A careful review of _________ can help geropsychologists learn more about the client’s medical history and current prescription medications.
3. Geropsychologists often assess an older client’s ability to perform __________, such as eating, dressing, and bathing.
You can find the answers in the Answer Key at the end of the book.</td></tr>
</table>

Treatment of Older Adults

Section Preview Here we summarize the most common late-life psychological disorders, the most prominent evidence-based psychological treatments for older adults, and some of the considerations and adaptations that may be required when providing those treatments. We describe pharmacological approaches to treatment and the need to guard against potentially dangerous interactions among multiple prescription drugs.

Anxiety, mood, sleep, and substance use disorders are some of the most common types of psychopathology seen in older adults, but with the exception of suicidal behavior, the prevalence of these disorders is lower than in other age groups (Byers et al., 2010; Sutin et al., 2013; World Health Organization, 2014). However, somewhat higher numbers of older adults experience symptoms of disorder whose intensity falls just below the threshold to qualify for a clinical diagnosis. Subthreshold symptoms of depression, for example, affect older adults' quality of life and therefore deserve clinical attention (Meeks et al., 2011). The prevalence of some disorders in older adults varies depending on their circumstances. For example, rates of depression among nursing home residents are considerably higher than among older adults living in the community (Lee et al., 2013).

Special Considerations in Treating Older Adults

Geropsychologists must take into account a number of special considerations when treating older adults. For one thing, these clients may have significant impairments in cognitive processing speed, memory, and reasoning. About half of people aged 65 and older report memory problems, up to 42% experience mild cognitive impairment (Moyer, 2014) and, like Mrs. Bagdonas, about 10% have some form of dementia (Hudomiet, Hurd, & Rohwedder, 2018). If severe enough, cognitive impairment may render certain psychological treatments ineffective, but in other cases, it may be enough for geropsychologists to conduct treatment sessions at a slower pace, to be ready to repeat themselves, to simplify instructions, and to provide written versions of between session "homework" assignments. To ease the emotional and cognitive demands of psychotherapy, geropsychologists may also offer shorter, more frequent sessions, scheduled during parts of the day when clients' physical and psychological strength is usually highest (Segal, Qualls, & Smyer, 2018).

Second, many older adults have both medical and psychological disorders (Chen et al., 2017), each of which can worsen the other and complicate assessment and treatment. For example, anxiety can amplify dyspnea (shortness of breath) and dyspnea can increase anxiety. There is a similar relationship between depression and chronic pain. Depression tends to magnify the pain associated with a physical or medical condition, thus limiting a person's ability to enjoy favorite activities and leading to further declines in mood. And older adults who believe our society's negative stereotypes about old people—such as that they all have bad memories,

shouldn’t exercise much, and have no interest in sex (Gewirtz-Meydan et al., 2018; Ory et al., 2003)—may underperform on cognitive tests, avoid working out, and miss out on an important source of pleasure. Sadly, such internalized **ageism** may contribute to their cognitive impairment, cardiovascular dysfunction, and even mortality (Levy et al., 2002, 2012). In short, failure to recognize the interaction of physical and psychological factors in their older adult clients can seriously interfere with the success of geropsychologists’ treatment efforts.

Ageism
Bias or prejudice against older adults based on stereotypes about that age group.

Third, geropsychologists recognize that older adults’ perceptions of and expectations for treatment, as well as their views about privacy, sexuality, gender roles, and other topics that are likely to come up in psychotherapy can differ significantly depending on when the clients were born. Members of the baby boomer generation, for example, tend to be relatively open to receiving psychological treatment and generally hold positive attitudes about it (Mackenzie et al., 2008). Members of earlier generations may view the need for mental health services as a personal or spiritual failure (Lebowitz & Niederehe, 1992).

Fourth, older adult clients may present geropsychologists with problems other than psychopathology. They may need help to cope effectively with the

stress of retirement (Sterns & McQuown, 2015), of moving in with an adult child or entering an assisted living facility. Relocation can be particularly difficult if it means losing lifelong friends, a familiar home, and comfortable routines. Other clients may need help to cope with the stress of bereavement following the death of a spouse or partner (Neimeyer & Holland, 2015), of taking care of a spouse or partner with Alzheimer's disease (Gilhooly et al., 2016), or even of suddenly having to raise grandchildren (Scheckler, 2018). Geropsychologists work with older adults who are dealing with the physical, psychological, and spiritual consequences of receiving a life-threatening medical diagnosis, or of simply facing the end of their lives (Carpenter, 2015). In such cases, treatment is likely to focus on helping clients to resolve past conflicts, accept their mortality, and gain insight and understanding about what their life has meant and the legacy they will leave behind (Chochinov et al., 2005).

Ethical Considerations. Whatever the treatment target, geropsychologists must remain aware that older adults' medical and cognitive problems can interfere with their capacity for insight and judgment. *Capacity* is a legal as well as a clinical term that pertains to a client's ability to make decisions, including the decision to consent to treatment (Lichtenberg, Qualls, & Smyer, 2015). If an older adult doesn't have the mental capacity to make that decision, the geropsychologist may not proceed unless someone in the client's family or some other health-care surrogate is available to give permission.

As with all clients, confidentiality is another major ethical consideration, and because older adult clients may be enmeshed in a complex social network, geropsychologists must be careful to identify exactly who they are working for (e.g., the older adult alone, the older adult and that adult's child,

or perhaps an entire family). The answer will affect how, when, and with whom information about treatment will be shared. Typically, a signed release-of-information form governs these matters. If treatment is to take place in a health-care facility where electronic medical records can be seen by other providers, older adults (and their families) must be warned about the limits of confidentiality. With these limits in mind, geropsychologists are careful about what they write in medical records, usually sharing only information others need to know in order to best care for the client.

Treatment Methods and Settings

As is the case in other age groups, older adults may be treated individually or in couples, family, or group therapy. They are usually treated in private practice, mental health clinics, or other outpatient settings, but they may also be seen in partial hospitalization facilities, adult day-care programs, or inpatient hospitals. Some older adults—particularly those in frail health or with mobility or transportation problems—may be treated in their own homes.

Psychosocial Treatments. The psychological treatments used with older adults can be based on the psychodynamic, behavioral, cognitive behavioral, interpersonal, and humanistic approaches described in Chapters 6, 8, and 9, though often modified to accommodate these clients' age-related characteristics (Knight, 2004).

Evidence-based treatments for anxiety disorders in older adults include CBT, relaxation therapy, and supportive therapy (Ghaed, Ayers, & Wetherell, 2012). For insomnia, treatments include sleep restriction or sleep compression and multicomponent CBT (Dillon, Wetzler, & Lichstein, 2012). Evidence-based treatments for depression include group CBT, group life-review therapy, interpersonal psychotherapy (with or without antidepressant medication), problem-solving therapy, and individual CBT (American Psychological Association, 2019). Acceptance and Commitment Therapy has also shown promise (Petkus & Wetherell, 2013; Wetherell et al., 2015).

Pharmacological Treatments

Many older adults prefer to address their problems via psychotherapy rather than prescription drugs (Bower & Wetherell, 2015), but research suggests that they may sometimes benefit from a combination of the two. Still, for several reasons, geropsychologists and geriatric physicians must be cautious when including drugs in a treatment plan. First, older bodies absorb, distribute, metabolize, and eliminate drugs differently than younger ones do, so older adults may need lower than normal doses. Second, as mentioned earlier, older adults are likely to be taking several medications, which can increase the chances of negative drug-drug interactions (Arnold, 2015). Third, many psychotropic drugs, including older antidepressants, antipsychotics, and anti-anxiety medications, can increase the risk of falls, impair cognition, or have other negative side effects that may outweigh their limited benefits in older adults (American Geriatrics Society, 2012). Fortunately, newer antidepressants such as selective serotonin reuptake inhibitors (SSRIs) and serotonin-norepinephrine reuptake inhibitors (SNRIs) have lower risks for older adults, so it is vital for geropsychologists to work closely with medical providers to reduce potentially harmful side effects and drug interactions.

A Case Example

As described earlier, Dr. Eleanor Parker conducted a clinical assessment with Danutė Bagdonas and, because she saw clear symptoms of depression, recommended weekly sessions of individual cognitive behavior therapy (see Chapter 9). At the first of these sessions, Dr. Parker describes the value of changing Danutė's routine so as to increase the number of pleasurable events she experiences each week. Using some of the motivational interviewing techniques described in Chapter 8, she helps Danutė to address the pessimistic attitude she's had about her ability to get out and do more things, and Danutė says she is willing to try becoming more active. Dr. Parker then works with Danutė to make a list of enjoyable activities, and Danutė agrees to start by attending at least one church-related event each week and to have lunch once a week with Marlena, one of her few remaining friends in the neighborhood. In the course of this session, Dr. Parker discovers that Marlena takes a weekly water exercise class, and Danutė agrees to ask Marlena about joining the class, too. To evaluate the impact of these activities, Dr. Parker gives Danutė a form on which she can list the ones she completes and rate her mood before and after each.

In later sessions, Dr. Parker monitors the success of these behavioral interventions, and also encourages Danutė to talk about her declining health and her negative thoughts about the future. Dr. Parker explains that these negative cognitions can themselves make her feel worse about herself, lowering her mood and worsening her depression. Together they work on identifying such cognitive distortions as all-or-nothing thinking ("My arthritis prevents me from doing anything for myself."), overgeneralization ("If I'm

unhappy today, I'm never going to be happy again."), and mind reading ("Lena and James are tired of worrying about me."). Dr. Parker prompts Danutė to challenge these self-defeating thoughts and come up with more realistic alternatives (e.g., "My physical condition will never be as it was when I was younger, but there are still things I can do that make me happy.").

Over these sessions, Danutė begins to build a more active and enjoyable routine, mainly by engaging in several of the activities she had planned. She and Lena also have an appointment with her primary care physician, who collaborates with Dr. Parker to try a new nonsteroidal anti-inflammatory drug for Danutė's arthritis pain. He also starts her on one of the serotonin-norepinephrine reuptake inhibitors mentioned earlier that is less likely to cause negative side effects in older adults.

Dr. Parker also enlists the help of the rest of the Jackson family to support Danutė's more active and engaged lifestyle. She is invited to their house for dinner once a week, and James takes her to the grocery store every Wednesday. Rachel helps her grandmother learn how to chat online with relatives in Lithuania, and Lena takes Jamal and Janelle for occasional visits to Danutė's house where they help with her housekeeping. Lena also sets up a medication management service, which delivers pre-packaged prescriptions to her mother's home.

Dr. Parker reviews Danutė's progress each week, reinforces her accomplishments, and emphasizes her growing strengths. After eight weeks of treatment, Danutė's score on the GDS is down to just 3 out of 15, which represents a significant reduction in her depression symptoms. Danutė says she feels more energetic, is sleeping better, has enjoyed time with her friends and family, and is even feeling more hopeful about the future. Still uncertain is whether, and for how long, her dementia will allow Danutė to continue

living independently, but the recent changes in her thinking, activities, and social support seem to be helping.

In Review Treatment of Older Adults

Common late-life disorders	**Evidence-based treatments**
Anxiety	CBT, relaxation therapy, supportive therapy.
Insomnia	Sleep restriction—sleep compression, multicomponent CBT.
Depression	Individual or group CBT, group life-review therapy, problem-solving therapy, and interpersonal psychotherapy.
Special treatment considerations	Special attention to comorbid medical and psychological conditions, including cognitive impairment, and to clients' birth cohort. Treatment targets include psychopathology, as well as stress arising from retirement, relocation, loss of a spouse, and death and dying. Treatment pace and frequency may be adjusted to accommodate limits on stamina and impaired sensory/cognitive capacity. Ethical concerns regarding confidentiality and client's capacity to provide valid consent to treatment. Special attention to the possible impact of multiple prescription medications.
Pharmacological treatments	Older bodies may react more strongly to psychotropic medications. Some older medications increase the risk of physical

	and cognitive side effects in older adults. Newer medications such as SSRIs and SNRIs may be safer.

Test Yourself

1. Rates of anxiety and depression are _________ in older adults than they are in younger adults, but _________ rates are higher.

2. Older adults generally prefer _________ treatments to _________ treatments.

3. When older adults believe that all old people have bad memories, they are illustrating the impact of _____________.

You can find the answers in the Answer Key at the end of the book.

The Future of Geropsychology

Section Preview In this section, we highlight three factors that may change how geropsychologists will work with older adults in the future. These include an increased attention to diversity, the role of technology in the lives and mental health care of older adults, and the ongoing shortage of geropsychologists.

Diversity and Multiculturalism

As the size of the older adult population grows in the years ahead, so too will its diversity. By the year 2060, Whites will make up only 55% of the over-65 population; it was 78% in 2014. The proportion of older adults who are African Americans will grow to 12%, Asians and Pacific Islanders to 9%, and Hispanics to 22% (Federal Interagency Forum on Aging-Related Statistics, 2016). Other facets of diversity will also become increasingly important, including immigration history, gender identity, sexual orientation, education level, socioeconomic resources, and geographic location (i.e., rural versus urban). Age itself is an important facet of diversity. For example, the needs of the average 65-year-old are different than those of the average 95-year-old.

The expanding diversity of the older adult population will make it even more important that geropsychologists have assessment instruments that have norms for all the various combinations of clients' age, ethnicity, race, and the like. For example, expected performance on cognitive screening tests might be very different for older adults with little formal education and a history of work at unskilled labor compared to older adults with professional degrees who worked at cognitively demanding jobs. There will also be a need for psychotherapeutic approaches that are tailored to these varying demographic characteristics, where appropriate. For instance, compared to other clients, the focus of therapy for a gender nonconforming person who is coping with the death of a partner may have to include dealing with prejudice encountered in the health-care system or the funeral business.

Advancing Technology

The pace of change in modern work environments creates special stressors for older adults. Without supportive retraining opportunities, these people may find themselves squeezed out of work settings earlier than necessary, so geropsychologists may be called upon to help older adults stay productive and engaged on the job.

At the same time, advancing technologies are helping to address some of the challenges associated with aging, including the social isolation and loneliness that can have a serious negative impact on physical and mental health (Cacioppo & Cacioppo, 2018). Social media, for example, are providing platforms through which older adults can stay in touch with important people in their lives and engaged in their communities.

As networked devices in homes (the *internet of things*) become more prevalent, it will become easier to monitor the health and activities of older adults. A person’s wearables, kitchen appliances, and other devices will alert family members or health-care professionals if an older adult begins spending more time in bed, eating less, and reducing social contacts, or doing other things that signal depression or a medical problem. Artificial intelligence and machine learning applications will enable digital assistants to converse with older adults and identify changes in vocal patterns that indicate increased stress, anxiety, or hopelessness. By helping older adults to manage their medications safely or stay cognitively engaged, modern technologies will also help people maintain their independence longer. Robots may help with household tasks and physical care and also provide some digital social interaction.

Technology will also play an important role in improving access to mental health services, especially for older adults with mobility or transportation limitations, and those who live in rural settings. Geropsychologists will be able to reach more of these clients when assessment, psychotherapy, and consultation can take place online.

Unfortunately, advanced technology alone will not make up for the fact that there are simply too few geropsychologists in the field—or in training programs—to help the advancing tide of older adults who will need their specialized services (Institute of Medicine, 2012). One survey by the American Psychological Association found that only 3% of licensed psychologists in the United States identify geropsychology as their specialty, compared to 30% who identify as child and adolescent psychologists (American Psychological Association, 2015b). Unless this situation changes, most older adults who need mental health services will be seen by psychologists who have had only basic training for working with this age group, backed up by a network of geropsychologists who can be called in for more complex cases.

Will this situation change? It might, particularly if psychology students become more aware of the special mental health needs of older adults, and of the career opportunities and financial rewards associated with specialized training in geropsychology. That awareness might come from coursework, clinical experiences, and even personal relationships with older family members (Merz et al., 2017; Woodhead et al., 2013). And who knows? Perhaps reading this chapter will lead you to explore your own interest in entering the field of geropsychology and thus help strengthen its future.

Chapter Summary

The longstanding focus of clinical psychologists on assessing and treating adults has changed over the last four decades to the point that clinical child psychologists have become a prominent subgroup in the field. They have developed methods of classification, assessment, and intervention that are specialized for use with children and adolescents.

In dealing with these clients, clinical child psychologists pay special attention to the context of behavior and a whole range of developmental considerations. Taking all these special considerations into account means asking assessment questions about child clients that would usually not be asked about adults. It also means using assessment methods (e.g., behavior rating scales, interviews with clients and multiple informants, intelligence and achievement tests, and exploration of home and school context) that are used less frequently with adult clients.

Treatment of child and adolescent clients poses special challenges because children and parents often have different perspectives about a child's behavior and because a child's presence in therapy usually requires parental motivation and cooperation. There are a number of evidence-based treatments for disorders in children and adolescents, most of which fall in the behavioral and cognitive behavior therapy domains. Psychoactive medications are also frequently used to treat childhood disorders, though there is considerable controversy about this trend. Rather than dealing with childhood disorders after they appear, many clinical child psychologists would prefer early,

comprehensive, and long-term interventions designed to prevent these disorders.

Future directions in clinical child psychology include a greater emphasis on diversity, multiculturalism, making mental health services more accessible to clients, interdisciplinary research that includes both biological and environmental factors in understanding the development and treatment of childhood disorders, interdisciplinary practice that helps bring multiple professionals together to help children, and the use of technology to improve the psychological functioning of youth.

Demographic changes in the decades ahead will create a demand for psychologists who have specialized knowledge and training about the mental health needs of older adults. Geropsychologists can fill that demand, but because too few clinical psychologists currently have this specialized training, all of them will need at least some basic knowledge about aging.

When conducting assessments and treatment with older adults, geropsychologists must attend to some unique characteristics of this group. Older adults have especially long, complex, and diverse personal histories, and may have sensory and/or cognitive impairments, chronic health conditions, multiple medications, and limitations to their independence. These factors often interact with psychiatric disorders and alter how geropsychologists assess and treat older adults.

Although some clinical assessment tools have been developed specifically for older adults, some standard instruments have not been normed for this group. Similarly, a number of psychological treatments have been developed for, or validated with, older clients, but most treatments have not, and so must be modified. These treatments are offered in individual, couples and family, and group therapy formats, and in many settings,

including outpatient clinics, psychiatric hospitals, medical centers, residential facilities, at home, and even via telephone or the internet. Future technological developments may expand older adults' access to mental health care, and career opportunities in geropsychology will continue to expand, too.

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[1] We refer to "parents" for convenience throughout this chapter but we mean children's guardians, regardless of whether they are parents, grandparents, or have some other connection.

12

Clinical Psychology, Health, and Well-Being

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Contents

What Is Health Psychology?

Risk Factors for Illness

Illness Prevention and Treatment Programs

Improving Adherence to Medical Treatment

A Case Example of Health Psychology

Chapter Preview

In this chapter, we describe how clinical psychologists work with medical professionals to treat disorders, help patients to cope with the stress of medical conditions, and to increase patients' adherence to medical treatment recommendations. We also describe how psychological factors contribute to disease, focusing on relationships between psychosocial factors (such as stress, patterns of thinking) and physical factors (such as nervous system activity, circulation, immune system functioning). Next we describe psychological risk factors and treatment interventions for illnesses such as cardiovascular disease, chronic pain, and cancer.

In this chapter and the next, we discuss two specialized areas of clinical psychology—health psychology and neuropsychology—that illustrate how important it is for psychologists to study relationships between psychological and biological factors. We selected these areas because they have been some of clinical psychology's best "growth stocks" in the past 40 years. New research discoveries and expanding professional roles for clinicians have increasingly attracted psychologists to these areas.

What Is Health Psychology?

Section Preview In this section, we present some of the theoretical foundations of health psychology. Health psychologists pay special attention to the role of stress on physical and mental health. They also consider how external stressors combine with internal variables such as coping strategies, cognitive habits, and perceived social support to affect vulnerability and resilience to illness. Clinical health psychologists also specialize in helping patients dealing with acute and chronic diseases to cope, including people facing terminal illnesses.

Health psychology emerged in the 1970s as a specialty devoted to studying "psychological influences on how people stay healthy, why they become ill, and how they respond when they do get ill" (Taylor, 1995, p. 3). This subfield has enjoyed such rapid growth over the last 40 years that it now has its own division in the APA (Division 38) and its own journal, *Health Psychology*. Health psychology research is also often published in the *Journal of Behavioral Medicine, Psychosomatic Medicine,* and the *Annals of Behavioral Medicine.* Related professional organizations include the Society of Behavioral Medicine, the American Psychosomatic Society, and the Academy of Behavioral Medicine Research. Many graduate training programs in clinical psychology now include a track focused on health psychology, and some programs have developed health psychology as their major focus.

Health psychology

A psychological subfield devoted to studying psychological factors influencing health, illness, and coping with illness.

Health psychology is closely related to the larger field of *behavioral medicine*, which involves the integration of knowledge from the social/behavioral sciences (e.g., psychology, sociology, and anthropology), the biological sciences, and medicine into an interdisciplinary science focused on understanding and treating all types of medical disorders in the broadest possible ways. Health psychology and behavioral medicine follow the *biopsychosocial* model mentioned in Chapter 2. It holds that physical illness is frequently the result of biological, psychological, and social disruptions, and generates research on how psychological conditions and behavioral processes are linked to illness and health.

Canadian physician Sir William Osler is generally considered the founder of modern behavioral medicine because he maintained that psychological and emotional factors must be considered in order to understand and treat various diseases. In 1910, Osler gave a lecture in which he suggested that many symptoms of heart disease "are brought on by anger, worry, or sudden shock." These ideas are remarkably similar to contemporary proposals about how key psychological factors may be linked to heart disease.

Sir William Osler (1849–1919)
One of Osler's contributions to behavioral medicine was to require medical students and medical residents at Johns Hopkins University to learn to interview patients and listen carefully to psychological as well as physical clues to a correct diagnosis.

(Source: Bettmann/Getty Images.)

Osler's views were made more relevant by significant changes in the nature of illness in Western cultures during the 20th century. As recently as 100 years ago, most Americans died of acute infectious diseases such as pneumonia, typhoid fever, and tuberculosis. However, advances in education, sanitation, pharmaceuticals, and vaccination have all but eliminated these diseases, leaving chronic illnesses—heart disease and cancer, for example

—as the major threats to life (Currie, 2013; McGrady & Moss, 2013). Today, the top three causes of death—cardiovascular diseases, cancer, and respiratory diseases—are responsible for over 55% of deaths worldwide. These diseases are not only persistent in nature but also take years to develop. Further, the major risk factors for developing chronic illnesses include lifelong health-damaging behaviors such as smoking, unhealthy eating, sedentary lifestyles, and alcohol abuse (Inoue-Choi et al., 2017). Yet as few as 3% of people in the United States follow a healthy lifestyle (Loprinzi et al., 2016). Today, nearly half of all deaths that occur in the United States can be at least partially attributed to such risky behaviors (Patel et al., 2015). We now have evidence, for example, that behavioral and psychological factors contribute to the onset, progression, and severity of heart disease, ulcers, asthma, stomach disorders, some cancers, arthritis, headaches, and hypertension. Reversing this trend will require increased awareness of the problem, changes in public policy, greater availability and lower cost of healthy options, and most importantly, changes in community and individual efforts at promoting healthy behaviors.

Physicians and other health-care professionals are becoming increasingly aware of the contributions that health psychologists can make in their practices. For example, emotional distress, including that resulting from difficulties in coping with an illness, is a factor in up to 60% of all physician office visits (Pallak et al., 1995), but physicians are typically not trained to deal with such distress. So prevention and treatment of illness-related emotional distress increasingly falls to clinicians in the health psychology field. In short, health psychology has grown because evidence strongly shows that it does not make sense to treat diseases without taking into account the psychological, emotional and behavioral characteristics of the patients in

which those diseases occur (Feldman & Christensen, 2014; Gurung, 2018; Taylor, 2017). The type and amount of stress in patients' lives is one of the most important things to know about them.

Stress, Coping, and Health

Stress is the negative emotional and physiological process that occurs as people try to adjust to, or deal with, circumstances that disrupt, or threaten to disrupt, their daily functioning beyond their ability or perceived ability to cope (Dougall et al., 2013). The circumstances that cause people to make adjustments are called *stressors*. They range in severity from mild to extreme and include a wide array of everyday and unusual experiences such as family and social conflicts, health problems, feeling overwhelmed, losing a loved one, high work demands, academic exams, and suffering abuse or trauma. The physical, psychological, cognitive, and behavioral responses—such as increased heart rate, anger, poor decision-making, and impulsiveness—that people display in the face of stressors are called *stress reactions*. Our ability to manage stressors and stress reactions is an important factor in determining how healthy we are and how vulnerable we are to illness.

Stress
The negative emotional and physiological process associated with people's efforts to deal with circumstances that disrupt, or threaten to disrupt, their lives.

Stress and the Nervous System. Physiological reactions to stress include a pattern of responses in the central and autonomic nervous systems. The autonomic nervous system is particularly important because this is the

system that normally operates to balance the body's energy and related needs. Under optimal conditions, the two branches of the autonomic system, the sympathetic nervous system and the parasympathetic nervous system, operate in concert to help keep the body in a state of equilibrium.

Many researchers have investigated response patterns of the autonomic nervous system in an effort to understand the biological effects of stressors. One of the first and most influential of these researchers was Hans Selye (1956), who called activation of the sympathetic nervous system during stress the **general adaptation syndrome**, or GAS. The GAS begins with an *alarm reaction,* which is often called the *fight-or-flight* response because it helps us combat or escape stressors. The alarm reaction releases into the bloodstream a number of "stress hormones," including adrenal corticosteroids, catecholamines (e.g., adrenaline), and endogenous opiates (the body's natural painkillers). These hormones increase heart rate, blood pressure, and respiration, cause pupillary dilation, muscle tension, and the release of glucose and lipid reserves, and also focus attention on the stressor. If the stressor persists, or if new ones occur in quick succession, the alarm stage is followed by the *stage of resistance,* during which less dramatic but more continuous biochemical efforts to cope with stress can have harmful consequences. For example, prolonged release of stress hormones can create chronic high blood pressure, damage muscle tissue, and inhibit the body's ability to heal. If stressors continue long enough, the *stage of exhaustion* appears as various organ systems begin to malfunction or break down. In the stage of exhaustion, people experience physical symptoms ranging from fatigue, weight loss, and indigestion to colds, heart disease, and other more serious problems.

General adaptation syndrome
A pattern of physiological reactions to stressors that includes stages of alarm, resistance, and exhaustion.

Selye's model was an important contribution to the field of stress and disease research and provided a framework for thinking about how stressors can contribute to physiological changes and, ultimately, disease processes. However, the GAS model fails to account for the importance of cognitive, psychological, and perceptual factors in modifying how and which experiences would be experienced as stressors. In other words, the model does not allow for individual differences in the experience of stress. Thus, more comprehensive models that outline how stressors affect disease progression have been developed, so the GAS is not typically used as a framework in contemporary research.

Barbara Dohrenwend (1978) suggested a four-stage model of how stressors and stress reactions contribute to physical illness and/or psychological disorder. In the first stage, stressful life events occur, followed in the second stage by a set of physical and psychological stress reactions. In the third stage, these stress reactions are mediated by environmental and psychological factors that either amplify or reduce their intensity. Factors likely to reduce stress reactions include things like adequate financial resources, free time to deal with stressors, a full repertoire of effective coping skills, the help and support of friends and family, a strong sense of control over stressors, a tendency to be optimistic, and a view of stressors as

challenges. Stress-amplifying factors include things like poverty, lack of social support, inadequate coping skills, pessimism, a sense of helplessness, and seeing stressors as threats. In stage four, the interaction of particular stressors, particular people, and particular circumstances results in physical and/or psychological problems that may be mild and temporary (some anxiety, a headache, or a few sleepless nights) or severe and persistent (e.g., an anxiety or mood disorder, chronic insomnia, or physical illness).

Today, most health psychologists believe that stress results from interactions between people and their environments, not simply as a function of external events. They recognize, for example, that physical and psychological stress responses may arise not only because of obvious external stressors, but also because of events and situations that a person *perceives* to be threatening or demanding. Health psychologists also understand that people's perceptions of their ability to successfully cope with events and situations can have an impact on their experiences of and responses to stress. More and more research in this field is focusing on understanding how stress influences health and disease, not only by triggering health-risky behaviors, but also by potentially influencing biological functions directly.

For example, in 2007, the American Psychological Association commissioned an annual, nationwide survey called Stress in America that has uncovered interesting patterns in how and under what conditions Americans experience stress. The most recent survey (American Psychological Association, 2018e) explored generational differences in the experience of stress (see Figure 12.1), and uncovered factors that cause particular stress among people in "generation Z" (those who, at the time of the survey, were between 15 and 21 years old). Mass shootings, debates about immigration,

and the prevalence of sexual harassment and assault were reported as significantly more stressful among this group than among adults over the age of 65. Among African American and Hispanic adult respondents, 46 and 36%, respectively, reported that experiencing discrimination was an important source of stress.

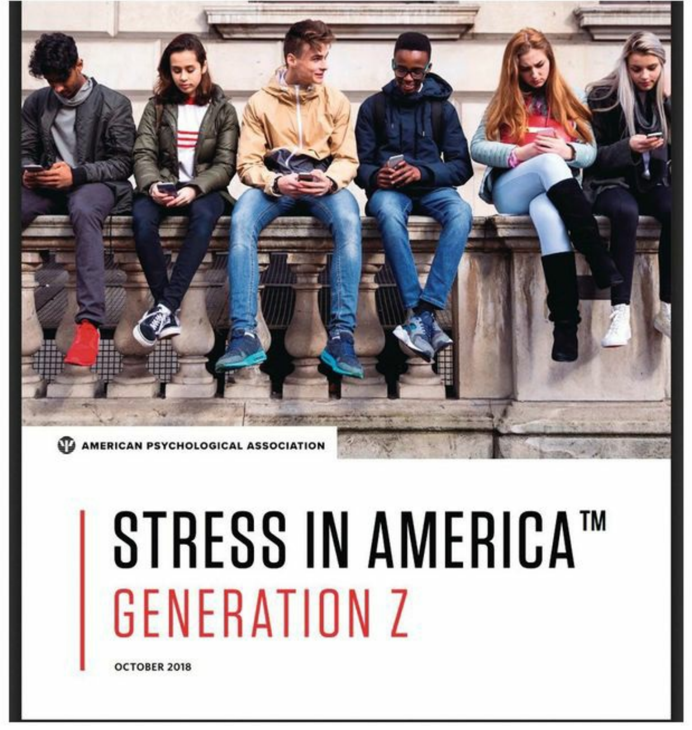

Figure 12.1 Generational Differences in Stressors

Try this Take a minute to visit the APA website, search for Stress in America, and compare your own sources of stress to those of the survey respondents of your own age. Talk to some friends and family members in both an older and a younger generation to learn about how your stressors compare to theirs. What similarities and differences did you discover?

Stress and the Immune System. Another important effect of prolonged stress is suppression of the immune system, the body's first line of defense against disease-causing agents (Dougall et al., 2013). For example, chronic

stressors such as caring for a seriously ill relative have been shown to lower immune system functioning, and even brief stressors, such as final-exam periods, have been associated with a decline in the activity of immune system cells that fight viruses and tumors (Kiecolt-Glaser & Glaser, 1992). In one series of studies, researchers measured the amount of stress experienced by a group of volunteers who had been exposed to cold viruses (Cohen, Tyrrell, & Smith, 1991; Cohen et al., 2012). The results showed that colds and other infections tended to appear in the volunteers who had experienced higher levels of stress, thus suggesting that a physiological mechanism—namely suppression of the immune system—is a major link between stress and infectious disease. Many researchers now suspect that immunosuppression—which is often due to inflammation—is the basis for the association between stressors and increased risk for illnesses, including some forms of cancer (Cohen & Rabin, 1998; Cohen et al., 2012).

As you might expect, lower levels of stress are associated with better immune functioning. This relationship was demonstrated in a study of married couples (Kiecolt-Glaser et al., 2005). On one day of the study, couples discussed an area of marital discord; on another day, they were asked to provide social support to each other and given prompts on how to effectively do so. Measures of wound-healing capacity and other immune system activity were taken during both days. Wound-healing capacity was significantly lower after the couples engaged in a stressful discussion of marital discord, and higher after they had provided each other with social support. But findings in this area of research, broadly called *psychoneuroimmunology*, can be quite complex. For example, although stressors—especially prolonged stressors—can suppress immune function, short bouts of stress can actually enhance activity in some portions of the

immune system (Segerstrom & Miller, 2004). These discrete bouts of stress appear to enhance the body's ability to respond to invasions of foreign substances (Atanackovic et al., 2006).

Developmental Aspects of Stress. Our health can be affected not only by the type and duration of stressors we experience, but also by when we experience them. For example, stressors that occur very early in life can have effects on psychological and physical health that echo throughout the life span (e.g., Young et al., 2019). So experiencing the stress of poverty, trauma, or other adversities during early childhood is associated with an increased risk of developing heart disease, arthritis, certain cancers, and other health problems in adulthood, even for people who by then had achieved middle or upper class socioeconomic status (Chan et al., 2011; Lehman et al., 2005). In short, childhood stress can have long-delayed effects.

One line of research has shown that traumatic early life experiences result in fundamental changes in the functioning of the brain and the cardiovascular and immune systems (Taylor, 2010; Agorastos et al., 2019). Even prenatal exposure to stress can alter *telomeres*, protein complexes that ensure stability of chromosomes and that are associated with long-term health and aging (Entringer et al., 2011; Lazarides et al., 2019). Identifying particularly stress-vulnerable times of life, and particularly stress-vulnerable individuals, will ultimately lead to a more complete understanding of how and when health psychologists can intervene to ensure optimal mental and physical health throughout the life span.

Measuring Stressors

To study the relationship between stress and illness, it is necessary to measure stress accurately, and health psychologists have tried to do so in several ways (Harkness & Monroe, 2016). One example is a questionnaire called the *Schedule of Recent Experiences* (SRE) (Amundson, Hart, & Holmes, 1986). It contains a list of 42 events involving health, family, personal, occupational, and financial matters, such as getting (or losing) a job, marrying or divorcing, being injured or ill, sexual dysfunction, death in the family, retirement, and the like. Respondents identify the events that have happened to them during the past 6, 12, 24, and 36 months, and then give each event a weight based on the amount of adjustment that was needed to deal with it (from 1, very little adjustment, to 100, maximal adjustment). These weights are summed to give a *Life Change Unit Score*. Although scales that measure life events have the advantage of being standardized, many researchers recognize that a simple listing of life events (even with an estimate of how much adjustment is necessary) do not capture the full impact of stressors. Factors such as whether the events have a positive or negative value and how expected or controllable they are also contribute to understanding the true impact of a particular event on particular individuals.

Many health psychologists believe that the most accurate assessment of stress comes not from evaluating environmental experiences but from assessing individual *perceptions* of stressors, which may be influenced by previous experiences, culture, gender, age, and a variety of other factors (Flores et al., 2010). Thus, some stress inventories ask respondents about the frequency and intensity of perceptions of stress without linking these

perceptions to actual events. Cohen's *Perceived Stress Scale* (PSS) is one such measure (Cohen, Kamarck, & Mermelstein, 1983; Novak et al., 2013).

The results of research with even the best stress assessment scales show that while there is undoubtedly a relationship between stress and illness, the strength of that relationship is not universal. In other words, even though people who are exposed to significant stressors are more likely overall to become ill than are those exposed to fewer stressors, most people who experience stressors do not become ill. This realization has led health psychologists to search for variables that might explain how people are protected from the potentially health-harming effects of stress. Among these variables are three particularly important *vulnerability* or *resilience factors* (Kessler, Price, & Wortman, 1985): adaptive coping strategies, stress-hardy personality characteristics, and social support.

Adaptive Coping Strategies

Coping refers to people's cognitive, emotional, and behavioral efforts at modifying, tolerating, or eliminating stressors that threaten them (Carver, 2011; Folkman & Lazarus, 1980). People vary in how they cope with stress. Some try to eliminate or otherwise deal with stressors directly; others attempt to change the way they think about stressors to make them less upsetting; still others concentrate on managing the emotional reactions that stressors cause (Lazarus, 1993).

Coping

People's cognitive, emotional, and behavioral efforts at modifying, tolerating, or eliminating stressors.

Richard Lazarus and Susan Folkman developed a *Ways of Coping* checklist consisting of 68 items that describe how 100 middle-aged adults said they coped with stressful events in their lives (Folkman & Lazarus, 1980). These items fall into two broad categories: *problem-focused* and *emotion-focused coping* (see Table 12.1). The 100 respondents reported on a total of 1332 stressful episodes, and in 98% of them, said they used both coping methods. Their choice was not random, however. Problem-focused coping was favored for stressors related to work, while emotion-focused coping was used more often when the stressors involved health. Men tended to use problem-focused coping more often than women in certain situations,

but men and women did not differ in their use of emotion-focused coping. Other researchers using different instruments have reached similar conclusions (Stone & Neale, 1984).

Table 12.1 Ways of Coping

Problem-focused and emotion-focused coping are two major ways in which people deal with stressors.

Coping Skills	Example
Problem-focused coping	
Confronting	"I stood my ground and fought for what I wanted."
Seeking social support	"I talked to someone to find out more about the situation."
Planful problem-solving	"I made a plan of action and I followed it."
Emotion-focused coping	
Self-controlling	"I tried to keep my feelings to myself."
Distancing	"I didn't let it get to me; I tried not to think about it too much."
Positive reappraisal	"I changed my mind about myself."
Accepting responsibility	"I realized I brought the problem on myself."
Escape/avoidance	"I wished that the situation would go away or

(wishful thinking)	somehow be over with."

Source: Folkman, S., Lazarus, R. S., Gruen, R. J., & DeLongis, A. (1986). Appraisal, coping, health status, and psychological symptoms. *Journal of Personality and Social Psychology, 50,* 571–579. Copyright 1986. Adapted with permission.

The distinction between problem-focused and emotion-focused coping has been a particularly useful guide to research for the last three decades (Compas et al., 2012). It is important to note, though, that particular ways of coping are not equally effective for all types of stressors. For example, people who rely entirely on active, problem-focused coping might handle controllable stressors well, but find themselves nearly helpless in the face of uncontrollable ones. Health psychologists help individuals under stress understand the range of coping responses possible for the specific stressors at hand.

Stress-Hardy Personality Characteristics

Psychologists interested in positive psychology have examined a variety of personality and cognitive characteristics, including optimism (Peterson, 2000; Seligman, 2008; Seligman & Csikszentmihalyi, 2000), resilience (Wright, Masten, & Narayan, 2013), faith and hope (see Myers, 2000), curiosity (Richman, Kubzansky, Maselko, & Kawachi, 2005), subjective well-being (Diener, 2012), and adaptive defense mechanisms (Vaillant, 2000), all of which can contribute to adaptive coping.

In some cases, the health benefits of these positive characteristics can be substantial. For example, one study measured both hope and curiosity in a large group of volunteers and, with their permission, tracked their health status as indicated by medical records. It turned out that those with higher hope and curiosity were less likely to develop high blood pressure, diabetes, and respiratory infections (Richman et al., 2005). Data such as these support the notion that positive emotional states may play a health-protective role. Psychological resilience has been found to serve as an important buffer against depression among individuals at high risk for depression, including those with adverse childhood experiences (Poole, Dobson, & Pusch, 2017) and veterans who have experienced high levels of lifetime trauma (Isaacs et al., 2017). Understanding the psychological and biological underpinnings of psychological resilience is an emerging area of research in health psychology because it may improve our understanding of how individuals can increase resilience in the face of adversity.

Other researchers in this area have investigated the role in physical and mental health of optimistic beliefs, including slightly overoptimistic

distortions of reality (“positive illusions”). A review of the literature in social psychology and related areas reveals, for example, that positively biased perceptions of reality are more common in people who are not depressed (Taylor et al., 2000). Healthy or mature defense mechanisms such as sublimation, altruism, suppression, and humor also appear to safeguard health and lessen the effects of some diseases (Vaillant, 2000; Kashdan & Rottenberg, 2010). A longitudinal study of Catholic nuns found that those who wrote about themselves in a positive emotional style early in life lived significantly longer and with less cognitive decline than those whose early writings contained less positive emotions (Danner, Snowden, & Friesen, 2001; Latimer et al., 2017; Snowden, 2003).

The benefits of positive attitudes do have their limits, however. For example, it may not be a good idea simply to act happy when you’re not. Efforts to inhibit or suppress negative emotions may have some short-term benefits but may be harmful to health in the long run (Salovey et al., 2000). One study found that rheumatoid arthritis sufferers who talked about stressful events more tended to have better outcomes than those who talked about such events less (Kelley, Lumley, & Leisen, 1997). Other research shows that people who write or talk about extremely stressful experiences (a process known as emotional expression or expressive writing) over successive days have more positive psychological and health benefits than those who do not (e.g., Pennebaker, 1995, 2004; Snowdon et al., 1999; Snowdon, Greiner, & Markesbery, 2000). Findings such as these are consistent with evidence that disclosure of negative emotions (such as in psychotherapy) is related to positive physical health, while inhibition is generally not (Miller & Cohen, 2001).

Certain questions about coping and positive psychology remain

unanswered. For example, what is the optimum balance of positive and negative expectations: Is it better to be optimistic or realistic? Optimism can often lead to self-deception and less careful cognitive processing, but without a certain amount of optimism, people may be more vulnerable to stressors (Schneider, 2001). Another question relates to how positive and negative experiences aggregate over time to affect health (e.g., Hostinar & Miller, 2019). Understanding how to promote psychological resilience is also an unanswered question. Finally, we have yet to delineate clearly which features of maladaptive coping are deeply ingrained and therefore difficult to change through therapy and which are less deeply ingrained and are therefore more easily and quickly changeable.

Social Support

Social support has been defined in many ways, but its essential element appears to be the experience and perception of being cared for, loved, esteemed, and part of a network of communication and mutual obligation (Baumeister & Leary, 1995; Hornstein & Eisenberger, 2018). Social support, then, involves more than the presence of others. It provides relationships in which emotional support, feedback, guidance, assistance, and values are exchanged.

Social support
The experience and perception of being cared for and part of a network of communication and mutual obligation.

How can social support influence health? Two main pathways have been examined. The first is the stress-buffering pathway, whereby the experience of stress is lessened as a consequence of the support provided. The second is the direct effects pathway, where the experience of stress is directly impacted by changing the actual stressor. In fact, there are many types of social support and research has demonstrated that these can have unique impacts on health and well-being (see Table 12.2). For example, emotional support has been shown to have more powerful stress-buffering effects than other types of social support, so it appears important to provide the type of support needed by particular individuals in particular situations.

Table 12.2 Types of Social Support

Type	Definition	Example
Appraisal Support	Helps individuals to identify their own resources and coping abilities and expresses confidence in success.	Helping someone recognize (and not exaggerate) the magnitude of threat posed by a stressor and identifying the internal resources available to manage the threat.
Emotional Support	Provides empathic listening and understanding a person's concerns.	Demonstrating an understanding of how someone feels about stressful situations.
Informational Support	Provides information and suggestions.	Providing useful knowledge about a medical question or advice on what to do.
Instrumental Support	Provides tangible assistance.	Giving someone a ride to the doctor's office; helping with childcare or household responsibilities.

Several studies have shown that the relationship between stress and illness is weaker among individuals who perceive high levels of social support in their lives (Brannon & Feist, 2009; Sarafino, 2010; Straub, 2011; Uchino et al., 2018). One explanation is that social support acts as a *buffer*

against stress. The buffer model claims that social support enables people who face intense stressors to neutralize those stressors' harmful effects. Social support also provides more opportunities for self-disclosure, and friends are likely to bolster efforts at constructive coping, thereby lessening the chances of self-defeating strategies such as excessive drinking and engaging in other health-damaging behaviors (Myers, 2000; Thoits, 1986). In short, people's perception of social support can strengthen their belief that others care for and value them; it may also enhance their self-esteem and increase feelings of confidence about handling stress in the future.

Another view, sometimes termed the *direct-effect* model, holds that social support is helpful regardless of whether stressful events are experienced because there is a general health benefit to being embedded in supportive relationships (Baumeister & Leary, 1995). A third explanation for the apparent benefits of social support is that high levels of support, good health, and low levels of stress all reflect the influence of some underlying characteristic such as *social competence*, which has positive effects on many areas of functioning.

Of course, some combination of all three models may be operating. It does seem clear that lack of social support, and particularly lack of emotional support, puts people at higher risk for both physical and psychological disorders (Cohen & Wills, 1985; Kessler, Price, & Wortman, 1985) and even premature death (McGrady & Moss, 2013; MacNeil-Vroomen et al., 2018).

Despite its general advantages, social support can carry some risks (Zee & Bolger, 2019). For example, having a dense social support network entails increased exposure to large numbers of other people, which increases one's exposure to communicable diseases. Social ties can also create conflicts if others' helping efforts leave the recipient feeling guilty, overly indebted, or

dependent. Recipients who are not able to reciprocate helping efforts may feel disadvantaged in future interactions with the donor. In other instances, potential helpers may behave in misguided ways (giving too much advice or becoming upset when their advice is not followed) that lead the recipient to feel invaded, incompetent, or rejected (Cohen, 2004, Malarkey et al., 1994; Lee et al., 2019; Wortman & Lehman, 1985). Also, if social support is primarily obtained from a single, even if large, social network, loss of support from that network because of conflict, change in location, or other reasons can lead to social isolation and devastating psychological consequences. Finally, those with close social ties may be particularly vulnerable to peer pressure to engage in health-damaging behaviors.

In Review What Is Health Psychology?

Main Concepts	Description
Health psychology	A subfield of psychology related to behavioral medicine, which highlights the links between physical illness and biological, psychological, and social factors.
Stress and stressors	Circumstances called stressors require people to make adjustments to them. Measurement of stressors includes identification of objective stressful events as well as people's individual perceptions of those events.
Stress reactions	Responses to stressors that appear as physical, psychological, cognitive, and behavioral changes, including suppression of the immune system. The severity of stress reactions can be reduced by factors such as effective coping skills, stress-hardy personality traits, and adaptive social support.
General Adaptation Syndrome	A pattern of changes in the autonomic nervous system in response to stressors; consists of alarm (fight or flight), resistance, and exhaustion stages.
Stress coping	Usually involves psychological and behavioral strategies aimed either at addressing and changing stressors (problem focused) or thinking differently about them (emotion focused).
Test Yourself **1.** Facing a difficult final exam would be considered a _________ while the	

resulting anxiety would be considered a _________________.

2. Health psychologists see health and illness related to many factors that combine as part of a ______________ model.

3. Someone who deals with stressors mainly by trying not to think about them is said to be using ___________ coping strategies.

You can find the answers in the Answer Key at the end of the book.

Risk Factors for Illness

Section Preview In this section, we examine risk factors for one of the most important illnesses that health psychologists study and help treat: cardiovascular disease.

Anything that increases a person's chances of developing an illness is called a *risk factor* for that illness. Some risk factors stem from biological and environmental conditions such as genetic defects or exposure to toxic chemicals, while others come in the form of health-damaging patterns of behavior. For example, smoking, overeating, lack of exercise, poor sleep habits, and consumption of a high-fat, low-fiber diet have all been identified as risk factors for life-threatening illnesses (Smith & Williams, 2013). Conversely, certain behaviors or lifestyles tend to promote health. For example, people who eat breakfast regularly, rarely snack between meals, exercise regularly, do not smoke, get 7 to 8 hours of sleep per night, and do not use alcohol excessively live longer than people who practice none of these behaviors (Smith & Williams, 2013).

Aggressiveness, anxiety, and depression, too, can act as psychological risk factors for illness by increasing physiological arousal, suppressing social support, and interfering with the pursuit of healthy lifestyles. The multifaceted influence of environmental, behavioral, and social risk factors is seen in several serious illnesses, including cardiovascular disease.

Risk Factors for Cardiovascular Disease

About half of the deaths each year in North America result from heart disease and stroke (Kochanek et al., 2013). That works out to an average of one death due to heart disease every minute. The list of predisposing risk factors for cardiovascular disease is long, and most of them are of direct relevance to health psychologists. They include family history, ethnicity, depression, anxiety, obesity, sedentary lifestyle, social isolation, hostility, and work-related stress (Schneiderman et al., 2001; Varvarigou et al., 2014). In fact, the American Heart Association describes “Life’s Simple 7” as a metric that individuals can use to identify some of the most important risk factors that determine cardiovascular health. Interestingly, four out of these seven factors are entirely behavioral and therefore controllable; the others are significantly influenced by behaviors and as such are at least partially controllable (see Table 12.3). Of course, labeling a behavior as controllable does not imply that it is easy for everyone (or anyone) to control it. For example, eating a healthy diet is usually more expensive than eating unhealthy food, but the fact that these risk factors are potentially controllable means we can take significant steps to reduce our risks and promote our health. Psychological factors are also important in managing risk for cardiovascular diseases. Let’s first consider the role of stressors.

Table 12.3 The American Heart Association Life’s Simple 7

Try this Consider this list of Life’s Simple 7 and make a note of how each might be relevant to you. How might you utilize a coping strategy discussed previously to support you in making a needed change in one of these domains? Then visit the American Heart Association website to do a self-

assessment of your ideal heart health score at https://www.heart.org/en/healthy-living/healthy-lifestyle/my-life-check--lifes-simple-7

Health Goal	Specific Details	Level of Controllability
1. Get active	Increase physical activity.	Controllable. Moderate aerobic exercise for at least 150 minutes per week or vigorous exercise for at least 75 minutes per week is a healthy goal.
2. Eat well	Eat a diet rich in vegetables, fruits, whole grains, fish, nuts, and low-fat dairy foods.	Controllable.
3. Maintain a healthy weight.	Lose weight if you are overweight or obese.	Controllable.
4. Control cholesterol	Cholesterol is essential to health and your body makes all the cholesterol it needs. Family history can influence cholesterol levels.	Cholesterol can be modified by diet, adherence to cholesterol-lowering medications if prescribed, and maintaining a physically active lifestyle.
5. Manage blood pressure	Check blood pressure and work with your health-care provider to keep it well-	Blood pressure is influenced by stress, body weight, and diet. Physical activity can

	controlled.	help to manage high blood pressure.
6. Reduce blood sugar	Blood glucose is important but work to reduce excess consumption of sweets and sugary drinks.	Controllable by modifying diet.
7. Stop smoking	Stop smoking if you do; don’t start if you are currently smoke-free.	Controllable. Use physical activity and other stress-reduction strategies to help quit.

The Role of Stressors. Some of the first strong evidence for the role of stressors in cardiovascular disease came from research on monkeys’ responses to various types of stress (Manuck et al., 1988; Manuck, Kaplan, & Clarkson, 1983). Researchers wanted to know whether increases in cardiovascular and endocrine reactivity caused by stressors can, if repeated many times over several years, produce the kinds of changes in the heart or peripheral arteries seen in cardiovascular diseases. The answer appears to be yes; animals showing the greatest increase in heart rate in response to stressors also had significantly more plaque—a build-up of cholesterol and other fatty substances—in their coronary arteries than did animals whose reaction was less extreme. Such an increase in plaque formation makes it more difficult for blood to flow easily through the arteries of the body and is an underlying cause of clinical events like heart attack (lack of blood flow to the heart leading to tissue damage and sometimes death), angina (diminished blood flow leading to pain), and stroke (blocked blood flow in the brain). The

extent to which this same phenomenon occurs in the same way in humans is an area of controversy.

There is no question though that, as noted earlier, people do react to threatening stimuli and other stressors with increases in heart rate, as well as with pronounced changes in blood pressure, and secretion of epinephrine, norepinephrine, and other stress hormones along with lipids (fats) for energy (Anderson, 1989; Krantz & Manuck, 1984; Stoney et al., 2002). In the short run, these changes are biologically adaptive because they provide the immediate increase in energy required to respond to many types of physical threats (the fight-or-flight response). Under optimal conditions, such changes in biological functioning return to normal soon after a stressor ends. However, if repeated stressors continually stimulate excessive cardiac activity, these normal biological changes may not be adaptive. To date, however, there is very limited evidence that such changes lead directly to the development of disease and this is an area of active investigation in the field.

Demographic variables such as ethnicity, education, and poverty are also related to the risk for cardiovascular diseases (Adler & Matthews, 1994; Kinge et al., 2019), in part because health-damaging behaviors tend to be inversely related to socioeconomic status (SES). Smoking, for example, is more common among less educated people, as is excessive drinking. Those with lower levels of education are less likely to work and, when they do work, are more likely to find themselves in higher-risk occupations and environments. Residents of poorer neighborhoods also display higher rates of obesity than do residents of higher income neighborhoods (Morland et al., 2006). Obesity, in turn, significantly increases people's risks for hypertension and coronary heart disease (e.g., Aune et al., 2016; World Health Organization, 2018b). These variables, along with others such as racial or

ethnic discrimination, low income, incarceration, and exposure to violent or otherwise stressful environments are sometimes referred to as *social determinants* of health. These factors are increasingly being examined as critical for understanding the influence of biopsychosocial factors on health outcomes. While individual interventions to counteract these factors can sometimes be helpful, minimizing their negative impact may require changes in social policies at the local, state, and/or national levels.

Other sociocultural factors can have an impact on health, too. For example, cardiovascular disease is about half as common among Chinese and Japanese Americans as among European or African Americans, while high blood pressure is about twice as common among African Americans as European Americans. Males, African Americans of both genders, and older people all suffer higher-than-average rates of heart disease and have higher-than-average blood pressure responses to certain stressors. Although the exact mechanisms explaining these differences are not yet clear, physical factors such as diet and cultural factors such as living in stressful environments are almost certainly important contributors.

Psychological Factors in Cardiovascular Disease. As noted earlier, the impact of stressors can be mediated by psychological factors, including whether we think about stressors as threats or challenges and whether we believe we can control them. People who feel helpless in the face of what they see as threats are likely to experience more intense physiological reactivity and emotional upset. On the other hand, those who view stressors as challenges, and feel confident about coping with them, may experience less reactivity and distress (Kleiman et al., 2016; Lazarus & Folkman, 1984; Maddi & Khoshaba, 2005).

The relationship between psychological factors and cardiovascular

disease can be quite complex, however, as is the case for people who used to be called *Type A.* These people were first identified by Meyer Friedman and Ray Rosenman, a pair of cardiologists who noticed that the front edges of the chairs in their shared waiting room were wearing out unusually fast. The upholsterer who did the repairs mentioned that there must be something different about the doctors' patients, and when they began to study the question, it turned out that there was. Many of their heart patients showed accelerated speech, a rapid style of living characterized by impatience, multitasking, competitiveness, dissatisfaction, preoccupation with personal accomplishments, and hostility (e.g. Matthews, 1982). It was these patients' inability to sit still while waiting for their appointments that led to premature wear of the chairs. Friedman and Rosenman (1974) suggested that Type A behavior is an important risk factor for the development of CVD; in one large study they found that Type A people had twice the incidence of heart attacks as more relaxed *Type B* individuals (Rosenman et al., 1975). Later research suggested, though, that not all aspects of Type A behavior are risk factors for CVD (Cohen & Reed, 1985; Eaker, Abbott, & Kannel, 1989; Miller et al., 1991; Ragland & Brand, 1988). It has been suggested that the most health-risky aspect of the Type A pattern is **hostility**, a trait characterized by suspiciousness, resentment, frequent anger, antagonism, and distrust of others that is not seen in all Type A people (Birks & Roger, 2000; Krantz & McCeney, 2002; Williams, 2001).

Hostility

A pattern of suspiciousness, resentment, frequent anger, antagonism, and distrust.

Thinking Scientifically Does Hostility Increase the Risk of Heart Disease?

Some see the focus on hostility as an important breakthrough in understanding the origins of CVD, but is hostility as dangerous as health psychologists suspect?

What am I being asked to believe?

Those who say yes claim that individuals who display hostility —especially when it is accompanied by irritability and impatience —increase their risk for coronary heart disease and heart attack (e.g., Bunde & Suls, 2006; Krantz & McCeney, 2002; Smith et al., 2007). This risk, they say, is independent of other risk factors such as heredity, diet, smoking, and drinking alcohol.

What kind of evidence is available to support the claim?

In one study, more than 1000 people with known heart disease reported on their own hostility. Those whose hostility scores were higher at the start of the study later had more heart attacks, strokes, or deaths as compared to those who had reported less hostility (Wong et al., 2013). Some evidence suggests that the risk of CVD is elevated in hostile people because these people tend to be overreactive to stressors, especially when challenged. During interpersonal conflicts,

for example, people predisposed to hostile behavior display unusually large increases in blood pressure, heart rate, and other aspects of autonomic reactivity (e.g., Brondolo et al., 2003). In addition, it takes hostile individuals longer than normal to get back to their resting levels of autonomic functioning (Gerin et al., 2006). These “hot reactors” may create excessive wear and tear on coronary arteries as their increased heart rate forces blood through tightened vessels (Johnston, Tuomisto, & Patching, 2008). Increased sympathetic nervous system activation also leads to surges of stress-related hormones from the adrenal glands. High levels of these hormones are associated with increases in cholesterol and other fatty substances that are deposited in arteries and contribute to coronary heart disease (Bierhaus et al., 2003). Some studies show that cholesterol levels are elevated in the blood of hostile people (Sahebzamani et al., 2013).

Hostility may also affect heart disease risk through its impact on social support. There is some evidence that hostile people get fewer benefits from social support (Lepore, 1995). Failing to use this support—and possibly offending potential supporters in the process—may intensify the impact of stressful events on hostile people. The result may be increased anger, antagonism, and, ultimately, additional stress on the cardiovascular system.

Are there alternative ways to interpret the evidence, including those that my biases and preconceptions might have kept me from seeing?

Studies suggesting that hostility causes coronary heart disease are not true experiments. Researchers cannot manipulate the independent

variable by creating hostility in randomly selected people in order to assess its effects on heart health. Accordingly, we have to consider other possible explanations for the apparent relationship between hostility and heart disease.

For example, a high-sugar diet contributes to heart disease and may also be associated with negative attitudes (Mõttus et al., 2013), so perhaps dietary choices could be the link between poor heart health and hostile behavioral tendencies. There may also be a genetically determined tendency toward autonomic reactivity that increases the likelihood of both hostility and heart disease. If this is the case, then the fact that hostility and coronary heart disease often appear in the same people might reflect not just the effects of hostility but also a third factor—autonomic reactivity—that contributes to both of them. It has been suggested, too, that hostility may be only one of many traits linked to heart disease. Depressiveness, hopelessness, pessimism, anger, and anxiety may be involved, too (e.g., Burg & Abrams, 2001; Kubzansky, Davidson, & Rozanski, 2005; Nicholson, Fuhrer, & Marmot, 2005; Roy et al., 2010; Rugulies, 2003; Suls & Bunde, 2005; Wulsin & Singal, 2003).

What additional evidence would help evaluate the alternatives?

One way to test whether hostile people’s higher rates of heart disease are related specifically to their hostility or to a more general tendency toward intense physiological arousal is to examine how these individuals react to stress when they are not angry. Some researchers have done this by observing the physiological reactions of hostile people during the stress of surgery. One study found that even under

general anesthesia, such people show unusually strong autonomic reactivity (Krantz & Durel, 1983). Because these patients were not conscious, it appears that oversensitivity to stressors, not hostile thinking, caused their exaggerated stress responses. This possibility is supported by research showing that individuals who have strong blood pressure responses to stressors also show different patterns of brain activity during stress than other people do (Gianaros et al., 2005). The importance of stress reactivity is also suggested by research showing that heart attack patients whose cardiac rehabilitation program included stress management had better medical outcomes than those enrolled in standard cardiac rehabilitation without stress management (Blumenthal et al., 2016).

What conclusions are most reasonable?

Most studies continue to find that among generally healthy people, those who are hostile—especially men—are at greater risk for heart disease and heart attacks than other people (e.g., Wong et al., 2013). However, the picture is complex; it appears that many interacting factors affect the relationship between hostility and heart problems.

A more elaborate psychobiological model may be required—one that takes into account that: (a) some individuals may be biologically predisposed to react to stress with hostility and increased cardiovascular activity, each of which can contribute to heart disease; (b) hostile people help create and maintain stressors through aggressive thoughts and actions, which can provoke others to be aggressive; and (c) hostile people are more likely than others to smoke, drink alcohol to excess, overeat, fail to exercise, and engage

in other heart-damaging behaviors (Kiecolt-Glaser, 2010). We must also keep in mind that the relationship between heart problems and hostility may not be universal. Although this relationship appears to hold for women as well as men and for individuals in different cultures, particularly Japan (e.g., Nakano & Kitamura, 2001; Yoshimasu et al., 2002), final conclusions must await further research that examines the relationship between hostility and heart disease in many other cultures, as well as in various racial and ethnic minority groups in Western cultures (Finney, Stoney, & Engebretson, 2002; Kitayama et al., 2015; Kuhlman et al., 2019).

In Review Risk Factors for Illness

Main Concepts	**Description**
Risk factor	Anything that increases a person’s chances of developing an illness.
Risk factors for cardiovascular disease	Genetics, smoking, unhealthy diet, lack of exercise, high cholesterol, poor sleep habits, depression, obesity, and environmental stressors are prominent examples. A combination of stress sensitivity and hostility is an additional factor.

Test Yourself

1. Heart disease and stroke account for about ______ of all deaths in North America.

2. Exposure to poverty, discrimination, and violence are examples of ________ determinants of health.

3. Research showing that hostile people tend also to be especially reactive to stressors provides evidence _______ the claim that hostility is the main psychological factor in cardiovascular disease.

You can find the answers in the Answer Key at the end of the book.

Illness Prevention and Treatment Programs

Section Preview In this section, we describe how health psychologists collaborate with physicians, health educators, and other professionals to develop programs for preventing and treating a variety of illnesses. The prevention programs are designed to reduce behavioral and psychological risk factors in specified populations, while treatment programs usually focus on helping medical patients (individually or in small groups) to minimize or cope with the symptoms of their illnesses. We highlight health psychology interventions related to cardiovascular diseases, pain, cancer, and HIV/AIDS.

Cardiovascular Diseases

As noted earlier, many people who do not currently have cardiovascular diseases or hypertension are at risk for these diseases because of the health-damaging behaviors they engage in and because of certain cognitive and psychological factors. These people may benefit from preventive interventions designed to reduce their risk.

With this in mind, health psychologists have developed programs aimed at eliminating smoking and other harmful habits, and at promoting regular exercise, low-fat diets, and other healthy habits (e.g., Azagba & Asbridge, 2013; Bui & Fazio, 2016; Feltner et al., 2016; Lin et al., 2014; Patnode et al., 2015; Spring et al., 2015). Some of these programs focus on a specific risk factor, such as obesity; others address several risk factors at once. Workplace interventions have become popular because corporations realize that these interventions reduce the cost of health care and because researchers find that health promotion programs based in work settings permit control over, and investigation of, several motivational and environmental variables (Feltner et al., 2016; Peng, 2009; Thompson et al., 2010). Community-based and internet-based interventions are also being tried, with some showing success in assisting individuals with behavior change (Bull et al., 2005; Glasgow et al., 2006), particularly because these interventions can be promoted widely. One of the first examples of multiple-component prevention programs was the Multiple Risk Factor Intervention Trial (MRFIT, 1982), which attempted to lower blood pressure, smoking, and blood cholesterol in thousands of high-risk individuals. Other prevention programs have been based in schools (Layzer, Rosapep, & Barr, 2014). Two of the earliest of these, the North

Karelia, Finland project (Williams, Arnold, & Wynder, 1977) and the Minnesota Heart Health Program (Blackburn et al., 1984) focused on interventions with children and adolescents. Although the North Karelia project was able to demonstrate a 73% reduction in deaths due to coronary heart disease over a 25-year period (Puska, 1999), others have been less successful (Ebrahim et al., 2006).

Pain

Pain may be the single most common physical symptom experienced by medical patients and is the most common reason that people visit a health-care professional, so pain management is an important objective in health psychologists' interventions with many disorders. They have focused their pain research and treatment on chronic pain conditions, headache, and rheumatoid arthritis (Cianfrini, Block, & Doleys, 2013; Keefe, Abernethy & Campbell, 2005). Their goals are to help patients to perceive less pain, to cope with the psychological distress associated with chronic pain, to decrease impairment of day-to-day functioning, and to develop strategies for more effectively living with chronic pain. As the opioid overdose crisis continues in the United States and elsewhere, it becomes especially important to develop psychological rather than just pharmacological treatments for chronic pain, and health psychologists are at the forefront of these efforts.

For headache and chronic pain, biofeedback and relaxation training methods have a long record of success, and cognitive behavior therapy techniques have also proven effective (Azar, 1996; Blanchard, 1992; Hazlett-Stevens & Bernstein, 2021). Encouraging healthy behaviors, such as adequate sleep, moderate physical activity when possible, and healthy diets is also an important part of managing chronic pain. And because pain is more severe when people are under stress (Rios & Zautra, 2011), stress management combined with cognitive behavior therapy is often effective for reducing many types of pain, including that stemming from arthritis (Young, 1992). These treatments also have some positive effects on the overall physical impairment associated with arthritis.

Clinicians working in health psychology also deal with *phantom pain*, which is the experience of pain that seems to be coming from a hand or other body part that has been amputated. Phantom pain can be extremely difficult to treat, partly because we do not fully understand its origins. One apparently successful approach is described in fascinating studies using a behavioral treatment called graded motor imagery, in which patients imagine performing motor movements in their missing limb using visual cues provided by mirrors and other devices. Patients treated in this way experience a significant reduction in phantom limb pain that had not responded to medications or other pain control methods (Barbin et al., 2016; Moseley, 2006).

Cancer

Health psychologists have developed a number of interventions designed to address several aspects of cancer (Andersen, et al., 2014; Baum, Reveson, & Singer, 2011). Their goal is to promote an improved quality of life for cancer patients by helping them to: (a) understand and confront the disease more actively; (b) cope more effectively with disease-related stressors; and (c) develop emotionally supportive relationships in which they can disclose their fears and other emotions. Behavioral techniques, such as relaxation training, hypnosis, stress management, and cognitive restructuring have proven especially useful. For example, one study showed that group therapy for breast cancer patients reduced stress and anxiety, improved perceptions of social support, resulted in decreased smoking and improved dietary habits, and may even have improved biological markers of disease (Andersen et al., 2004, 2010, 2016).

Progressive Relaxation Training

Health psychologists have helped cancer patients cope with the stress associated with their disease by helping them learn progressive relaxation

techniques, often combined with cognitive behavior therapy.

(Source: Paula Connelly/E+/Getty Images.)

Thankfully, recent advances in pharmacology have helped alleviate much of the actual nausea and vomiting associated with cancer chemotherapy, but health psychologists continue to help cancer patients with the other common effects of having cancer and cancer treatment, namely fatigue, pain, and depression (Faul & Jacobsen, 2012). A number of their psychological interventions, including relaxation training with guided imagery, progressive muscle relaxation, mindfulness, peer support, educational programs, acceptance-based therapy (see Chapter 9), and various kinds of supportive individual and group therapy, have been shown to improve the mental and physical well-being of many cancer patients (Andersen et al., 2010; Fawzy et al., 1995; Mens et al., 2016).

HIV/AIDS

Health psychologists have long been involved in AIDS prevention through programs designed to reduce the unprotected sexual contact and needle sharing that are known risk factors for HIV infection.

In one HIV/AIDS program aimed at African American teenagers at risk for HIV infection, participants were randomly assigned to either a single class on the basic facts about HIV transmission and prevention or to an eight-session program combining the same basic information with behavioral skills training. The behavioral skill training group engaged in role-playing and group activities designed to support sexual abstinence, safer sex practices, and resisting pressure to engage in unsafe sex. Teenagers in the behavioral skills group decreased their rate of unprotected intercourse significantly more than those in the single-class group, and this difference was still evident a year later. Further, among those who had been sexually abstinent when the study began, 88.5% of the teens in the behavioral training program remained so during the follow-up, while only 69% of the one-session information group was still abstinent (St. Lawrence et al., 1995). Success has also been reported following similar programs aimed at adult African American women in inner cities (e.g., Kalichman, Rompa, & Coley, 1996). In another program, gay men participated in 12 group sessions of role-playing, behavioral rehearsal, and problem-solving techniques designed to promote condom use and other safe-sex practices. Compared to a control group of gay men who did not receive training, program participants significantly increased their use of condoms, their resistance to sexual coercion, and their knowledge of AIDS risks (Kelly et al., 1989).

There are also programs aimed at preventing the further spread of HIV/AIDS by people who already have the disease. In one such study, 233 men and 99 women were randomly assigned to either a five-session group intervention focused on practicing safer sex or a five-session health-maintenance support group (a standard-of-care comparison). The safer sex practices intervention included emphasis on information, motivation, and behavioral skills. At 6-month follow-up, participants in the safe-sex practices intervention engaged in significantly less unprotected intercourse and significantly more condom use (Kalichman et al., 2001; see also Starks et al., 2013).

With the help of health psychologists, many large U.S. cities have established AIDS education programs, clean needle exchanges, condom distributions, and publicity campaigns encouraging safe sex (Kelly & Murphy, 1992; Koester et al., 2007). There are also AIDS prevention programs in many other countries, including those of sub-Saharan Africa, Asia, and parts of the Caribbean where women's AIDS risks have increased dramatically (Canning, 2006). A major goal of AIDS prevention programs in these countries is to empower women to learn about HIV transmission, take greater control of their sexual lives, obtain protective devices such as female condoms or vaginal microbicides, and become less economically dependent on men and therefore less subject to coerced or commercialized sex.

Health psychologists are also now focusing research on ways to improve HIV/AIDS patients' adherence to the sometimes-complex dosing schedules of modern antiretroviral therapy (ART) medications that have been shown to have substantial positive health benefits. They have found that mobile health interventions, such as text messaging and the use of cell phone apps, can improve that adherence, thus potentially offering an accessible and effective

means to promote health and reduce the transmission rate of HIV (Muessig et al., 2017).

Other psychological interventions attempt to help patients cope with HIV/AIDS itself. One study of such interventions compared the effectiveness of various kinds of individual psychotherapy for treating depression among HIV-positive patients (Markowitz et al., 1998). In this study, cognitive-behavior therapists focused on helping clients restructure their appraisals and replace unhelpful, distorted thoughts with more adaptive ones. Interpersonal therapists focused on mood and helped clients relate moods to interpersonal and environmental events and social roles. Supportive psychotherapy combined client-centered therapy with an educational component about depression. Yet another group received supportive psychotherapy plus an antidepressant drug. Reductions in depression appeared in each therapy group, but reductions were significantly better for interpersonal therapy and for supportive psychotherapy plus medication.

Can psychotherapy with HIV-positive patients help to slow the development of full-blown AIDS? In one study, 54 HIV-positive men were randomly assigned to a training program to enhance adherence to medication, while 76 others received the same training program plus a cognitive behavioral intervention (Antoni et al., 2006). The researchers wanted to know if the psychotherapy intervention might assist patients in adhering to and effectively coping with a complex medical treatment program and thereby improve the patients' immune function. Results indicated that, indeed, the 10-week cognitive behavioral plus medication adherence program was associated with improved immune function, whereas those in the adherence-only group showed no change.

In Review Illness Prevention and Treatment Programs

Target of Prevention and Treatment	Examples
Cardiovascular disease	Programs in schools and workplaces, and through public health campaigns to promote healthy lifestyles and discourage unhealthy ones.
Pain	Use of biofeedback, progressive relaxation training, cognitive behavior therapy.
Cancer	Progressive relaxation training, promotion of social support networks, stress management, acceptance-based therapy and cognitive restructuring.
HIV/AIDS	Training programs to promote safe-sex practices and resist pressure for unsafe practices; medication adherence programs, clean needle exchanges, condom distribution, and public health campaigns. Psychotherapy for patients who are HIV/AIDS positive.

Test Yourself

1. The need for health psychologists' non-pharmacological treatments for pain has dramatically increased because of what has been called the _______ epidemic in the United States.

2. Health psychologists cannot cure cancer, but they are helping cancer patients to ______ their illness.

3. As drugs have reduced nausea associated with cancer chemotherapy, health psychologists have focused on helping patients deal with other disease side effects such as ______, _______, and _______.

You can find the answers in the Answer Key at the end of the book.

Improving Adherence to Medical Treatment

Section Preview In this section, we review a set of behaviors that are essential for health, namely adherence to medical treatment recommendations. You will see that health psychologists help to identify the causes of nonadherence, and they also develop various interventions to improve adherence.

Psychological interventions aimed at disease prevention or symptom reduction often result in immediate improvements in healthy behaviors, but unfortunately, these changes may not be maintained long enough to promote a healthier life. Maintaining behavior change remains one of the most vexing problems in health psychology. For example, smoking cessation programs and anti-smoking medications usually result in significant rates of abstinence, but more than half of smokers who quit resume their habit within a year (e.g., Roberts, Kerr, & Smith, 2013; Robles, Singh-Franco, & Ghin, 2008). And although behavior modification appears to be the most effective psychological intervention for obesity, maintenance of weight loss and learning new eating habits are major difficulties for most people. Most psychologically oriented weight-reduction interventions can achieve reductions of about 1 pound per week, but it is difficult to maintain these reductions beyond 1 or 2 years, so there may be no significant health benefits (e.g., Tomiyama, Ahlstrom, & Mann, 2013). Similar difficulties are found even when patients try to alter their lifestyles after a heart attack. It would seem reasonable to assume that such a traumatic event might jolt people into permanent lifestyle changes, but as many as half of cardiac rehabilitation

participants drop out of their programs within 1 year (Ruano-Ravina et al., 2016).

The effectiveness of medical treatment, too, depends not only on its being the correct treatment but also on the patient's continued engagement with it. The extent to which patients adhere to medical advice and treatment regimens is called *compliance* or *adherence*. Research on the impact of adherence on medical outcomes makes it clear that adhering to treatment advice is important because some patients can end up worse than when they began if they fail to follow treatment regimens. Adherence can be affected by several factors, including the severity and chronicity of the disease, patients' age, the quality of the doctor–patient relationship, patients' perceptions of probable outcomes, and the type and complexity of treatment prescribed (DiMatteo et al., 2002; Moon et al., 2019). Nonadherence in taking prescribed medication may occur in at least half of all patients (Brown & Bussell, 2011). For example, many don't take their full course of antibiotic medication because they feel better shortly after beginning treatment (Branthwaite & Pechere, 1996). Nonadherence rates among parents who are providing medication for their children tend to be lower, but for some medications taken by adolescents, nonadherence rates can be as high as 80% (Rickert & Jay, 1995). Indeed, adolescents may not take prescribed medications at all, may take it less frequently or more frequently than instructed, or they may ignore rules about the need to take medicine with food or not to consume alcohol while on medication. Nonadherence tends to be especially common in treatments that are complicated, unpleasant, and involve substantial lifestyle changes and long-term consequences. Health psychologists have been involved in efforts to understand the causes of nonadherence and in developing interventions to improve adherence.

Causes of Nonadherence

One cause of nonadherence appears to be miscommunication between physicians and patients. Patients frequently do not understand what physicians tell them about their illnesses or their treatments. As a result, they are confused about what they should do or they forget what they have been told. One early study showed that five minutes after seeing their physician, general-practice patients had forgotten half of what the doctor had told them (Ley, Bradshaw, Eaves, & Walker, 1973).

Adherence is also correlated with the emotional aspects of patient–physician communication, including patient antagonism toward the physician and physician withdrawal from the patient. Adherence may also be reduced by the sheer complexity, inconvenience, or discomfort associated with some kinds of treatment. In cases where treatments have significant unpleasant side effects, for example, the effects of following a prescribed treatment regime may feel worse than the effects of the medical condition it is designed to treat. Finally, nonadherence to treatment may appear because patients do not have a good system for reminding themselves about what to do and when to do it.

The *health belief model* (Rosenstock, 1974) has been especially helpful in understanding the reasons for patient nonadherence. According to the health belief model, patients' adherence to treatment depends on factors such as: (a) how susceptible to a given illness they perceive themselves to be and how severe the consequences of the illness are thought to be; (b) how effective and feasible versus how costly and difficult the prescribed treatment is perceived to be; (c) the influence of internal cues (physical symptoms) plus

external cues (e.g., advice from friends) in triggering health behaviors; and (d) demographic and personality variables that modify the influences of the previous three factors.

Interventions to Improve Adherence

Attempts to improve adherence to treatment can be classified into three general approaches: (a) educating patients about the importance of adherence so that they will take a more active role in maintaining their own health; (b) modifying treatment plans to make adherence easier; and (c) using behavioral and cognitive behavioral techniques such as self-monitoring, reminder cues, and other tools to increase patients' ability to adhere.

Education. One direct and effective intervention for improving adherence to short-term treatments is to give patients clear, explicit, written instructions that supplement oral instructions about how treatment is to proceed. Educating physicians about the causes and management of nonadherence may also be beneficial. In one study, physicians who had been educated about the health belief model and ways to improve adherence had more adherent patients at a six-month reassessment than those who were not given that education (Inui, Yourtee, & Williamson, 1976). Education can also counteract inaccurate or naïve theories of illness that some patients may have.

Modifications of Treatment Plans. A second strategy for increasing adherence is to reorganize treatment to make it easier for patients to follow treatment instructions. Examples include timing daily doses of medication to coincide with daily habits (e.g., taking pills right after brushing teeth), giving treatment in one or two injections rather than in several doses per day, packaging medicine in dosage strips or with pill calendars, and scheduling more frequent follow-up visits to supervise adherence. These procedures have shown promise, but many of them entail additional manufacturing costs

and extra time from service providers, two characteristics that tend to limit their scalability.

Behavior Modification. As discussed earlier in relation to HIV/AIDS, health psychologists study and implement a number of behavioral techniques, including the use of motivational interviewing, telephone calls, wristwatch alarms, emails, text messages, smartphone apps, and other environmental cues to prompt patients to take pills or perform other aspects of treatment plans (e.g., Miller, 2012b). They have also set up written *contingency contracts* (described in Chapter 9) between patient and physician that specify patient behaviors that will earn rewards such as more conveniently timed office appointments. Such contracts encourage a more collaborative relationship between patient and physician and have been successful in improving adherence in many patients (Bosch-Capblanch et al., 2007).

Behavior modification procedures have also been used to reduce nonadherence motivated by the discomfort associated with medical procedures or treatments. The best-known illustration of these methods was described earlier in relation to behavioral treatments for the control of anticipatory nausea in cancer chemotherapy patients. Other examples include teaching children to use breathing exercises and distraction techniques to help them overcome fear of routine vaccinations, employing hypnosis to reduce pain in burn patients who are undergoing debridement (wound-cleaning) procedures, and using relaxation, exposure techniques, and participant modeling to help fearful patients get the dental work they need but have been avoiding.

In Review Improving Adherence to Medical Treatment

Main Concepts	**Description or Examples**
Medical treatment is of no value if patients do not comply with it	At least half of all medical patients fail to take medication or comply with other treatments.
Causes of nonadherence	Miscommunication or lack of communication between physicians and patients. Conflicts or antagonism between physicians and patients. Complexity and/or discomfort associated with treatment. Lack of an effective patient reminder system.
Interventions to improve adherence	Patient and physician education about the need for clear instructions. Making treatments simpler and easier to follow. Setting up self-monitoring and other reminder systems.

Test Yourself

1. The severity of a disease, the patient’s age and perception of the value of treatment, the quality of the doctor–patient relationship, and the complexity of treatment can all affect ____________.

2. The ___________model has been useful in understanding the causes of nonadherence to medical treatment regimens.

3. The principles of operant conditioning are being used to create ______________ between doctors and their patients aimed at promoting compliance.

You can find the answers in the Answer Key at the end of the book.

A Case Example of Health Psychology

Health psychologists often must consider conducting interventions outside of the normally defined roles of clinical psychologists, particularly when there is co-occurrence of several problems that are of both medical and psychological concern. Helping clients to increase exercise is one of these areas (Pollock, 2001). These nontraditional interventions are indicated because of research evidence that exercise can be as effective for some conditions as other, more traditional clinical interventions such as cognitive restructuring or emotional support. Several studies have found that exercise was at least as effective as antidepressant medication in reducing the symptoms of mild depression, and more effective in preventing relapse (Babyak et al., 2000; Josefsson, Lindwall, & Archer, 2013).

As an example of this approach, consider the case of Regina Bagdonas, the 45-year-old aunt of Rachel Jackson, whose family you met in Chapter 1 and throughout this book. Regina is Lena Jackson's older sister, and though she and Lena have been estranged for many years, she has kept in touch with Rachel, her favorite niece. Like Lena, Regina has not had an easy life. With only a high school education, a job as a poorly paid receptionist, no real friends, and two unsuccessful marriages in her past, she feels the stress of loneliness, fatigue, and financial pressure. In addition to her low energy level, lately she has been having trouble sleeping and sometimes feels her heart skipping beats. Because her father died of a heart attack, she has begun to worry about her risk for cardiovascular disease, a concern amplified by the fact that she eats an unhealthy diet and is considerably overweight. The idea

of seeing a psychologist had never occurred to Regina until an exchange of emails with Rachel about Rachel's recent beneficial experiences in therapy with Dr. Leon.

Regina could not afford private therapy, but to her surprise her company offered its employees a free wellness program run by a health psychologist named Jennifer Olson (not her real name). Regina signed up for the program, and at the first session described to Dr. Olson the physical toll that she believed her stressors were taking on her. Together, they undertook a review of Regina's health-related behaviors and the risks they posed for illness. As an evidence-based clinical scientist, Dr. Olson then reviewed empirical evidence about the short- and long-term benefits of various strategies for modifying each of Regina's health-risky behaviors. At the next session, Dr. Olson asked about Regina's preferences about where to start making changes, and about her hopes, motivation, and expectations for long-term success in each area. Through this process of shared decision-making, they jointly developed a treatment plan.

That plan included a series of weekly treatment sessions focused first on Regina's insomnia and then on her lack of exercise. They chose these targets because they agreed that, given her history and current situation, efforts at dealing with them could have the greatest chance of success and the most significant impact on her overall mood and health. Regina wanted to address both targets at the same time, but Dr. Olson had reviewed research suggesting that doing so can be challenging (Bush et al., 2018). In this case, asking Regina to start an exercise regimen while being sleep deprived could lead to failure in both realms.

Over the next several weeks, Dr. Olson used cognitive-behavior therapy and progressive relaxation training to help Regina sleep better, and once that

problem was under control, guided Regina to engage in a graduated program of diet and exercise. Together, these programs led Regina to feel better, not only physically, but psychologically as well. She began to feel that she now had a longer life ahead of her and was more optimistic about what it might bring.

In providing treatment, Dr. Olson was guided by a *transtheoretical model* (Prochaska et al., 1994; Prochaska & DiClemente, 2005; see Table 12.4). This model is designed to assess a client's readiness to change. For some behaviors, the change would involve an inhibition of a behavior (e.g., smoking or substance use), while for others the change would involve initiation of a behavior (e.g., physical activity). In both cases, interventions are shaped according to the stage of readiness. The first three of the five stages in this model involve a person's cognitive readiness for change, while the final two stages involve the continuity and maintenance of the behavior change (Prochaska, DiClemente, & Norcross, 1992).

Table 12.4 A Transtheoretical Model for Assessment and Intervention

Stage	Description
Precontemplation	The person does not perceive a health-related behavior as a problem and has not formed an intention to change.
Contemplation	The person is aware that a health-related behavior should be changed and is thinking about it.
Preparation	The person has formed a strong intention to change.
Action	The person is engaging in behavior change. (Relapse

	and backsliding are common at this stage.)
Maintenance	After behavior changes have begun, the person must continue performing and/or avoiding specified behaviors.

Source: Based on J. O. Prochaska, W. F. Velicer, J. S. Rossi, M. G. Goldstein, et al. (1994). Stages of change and decisional balance for 12 problem behaviors. *Health Psychology*, *13*, 39–46.

The transtheoretical model is only one of many models within health psychology that address cognitive factors involved in people's decision to change health-related behaviors (see Rothman, 2000).

Chapter Summary

Health psychology is a specialty devoted to studying psychological, behavioral, and social influences on health, illness, and coping with health problems. It is closely related to the larger field of behavioral medicine, which involves the integration of knowledge from many disciplines in understanding and treating medical disorders. Both fields adopt a biopsychosocial model in which physical illness is viewed as involving biological, psychological, and social factors. Health psychologists seek to: (a) understand how these factors interact to influence illness and health; (b) identify risk factors for sickness and protective factors for health; (c) promote healthy behaviors and prevent unhealthy ones; and (d) create interventions that contribute to the medical treatment of illness.

Stress is the negative emotional and physiological process that occurs as people try to deal with perceived threats, called stressors, that disrupt or threaten to disrupt daily functioning when people do not perceive that they have the ability to cope with those threats. Stress reactions can be physical, psychological, and behavioral. Physical stress reactions include the general adaptation syndrome, which begins with an alarm reaction and, if stressors persist, continues into the stages of resistance and exhaustion. Prolonged stress can result in immunosuppression, impairment of the body's disease-fighting immune system, and excessive sympathetic nervous system activation. The impact of stressors tends to be lessened in people who perceive stressors as challenges rather than threats, and who have strong

social support systems. Lack of social support increases risk for physical disorders.

Anything that increases the chances of developing an illness is called a risk factor for that illness. Behaviors associated with risk for cardiovascular disease and cancer include smoking, overeating, lack of exercise, and consumption of a high-fat diet. Stressors, hostility, and depression also appear to be risk factors for cardiovascular disease.

Illness prevention programs in health psychology seek to reduce risk factors for cardiovascular disease, chronic pain, cancer, AIDS, and other diseases by working with individuals, groups, and whole communities to alter health-risky behaviors. Health psychologists often treat individuals with multiple health problems, and decisions must be made about which conditions have priority. Although many types of interventions are initially successful, long-term behavior change is difficult in some areas, particularly those involving strongly entrenched habits (e.g., smoking, substance abuse, sedentary behaviors, overeating) and behavioral changes that must be sustained over a long period of time.

Health psychologists’ efforts to improve patients’ adherence to prescribed medical treatments include education about the importance of adherence, modifying treatment plans to make adherence easier, and using behavioral techniques to increase patients’ ability to adhere.

13

Clinical Neuropsychology

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Contents

A Brief History of Neuropsychology

Basic Principles of Neuropsychology

Patterns of Neuropsychological Dysfunction

Neuropsychological Assessment

Neuropsychological Approaches to Psychopathology

The Current Status of Clinical Neuropsychology

Chapter Preview

Clinical neuropsychologists perform assessments and design interventions for patients who experience neurological dysfunction because of brain injury or illness. They also conduct research on both normal and abnormal brain functioning. That research has helped to shed light on psychological disorders such as depression and schizophrenia, and on neurological disorders such as Alzheimer's disease or the effects of a concussion. Clinical neuropsychology is a relatively new and growing field, and its practitioners must understand brain–behavior relationships and be trained in a variety of assessment and intervention techniques unique to the field.

A Clinical Case

Some months after having advised Lena Jackson to seek help for Lena's daughter, Rachel, Ellen Yang was in a serious automobile accident. Because her car's airbags failed to deploy, her head hit the steering wheel, she lost consciousness, and a friend in the passenger seat was killed. Ellen went on to make a full physical recovery, but she had some new problems. She forgot conversations, missed appointments, failed to meet deadlines, lost things, and asked the same questions again and again. How would you explain these new problems? You could consider several possibilities. For example, you might wonder if she is still upset about the accident, is mourning her lost friend, or perhaps feeling guilty about having survived. Such emotional turmoil could impair concentration and cause forgetfulness.

But how could you know whether, instead, brain damage was the cause? You might look at pictures of her brain structure with magnetic resonance imaging to spot areas of gross brain damage. But those pictures can't tell you if the damage is fresh or old. Most important, you would still have to decide if the damage is relevant to Ellen's current problems. In other words, you would need to decide if the damaged regions are those which, when injured, could cause the specific problems with memory or thinking that Ellen is having. Further complicating the picture is that brain damage on a microscopic or cellular level can impair psychological functioning but be invisible on an imaging scan. To help sort out all these possibilities, you need a way to carefully assess Ellen's mental abilities. You must then use detailed knowledge of psychology and brain function to decide if the pattern of findings suggests brain dysfunction, and if so, where it is. These are some of the tasks that clinical neuropsychologists perform.

Neuropsychology is the field of study that seeks to understand how brain processes make human behavior and psychological functions possible (Heilman & Valenstein, 2011). Neuropsychologists are interested in a wide range of human abilities, including aspects of cognitive functioning (e.g., language, memory, attention, mathematical, planning, and visuospatial skills), motor functioning (e.g., learned skilled movements, gross and fine motor skills), emotional functioning (e.g., motivation, understanding and expressing emotion, anxiety, depression, euphoria), social functioning (e.g., prejudice, social judgment, interpreting social cues), and personality traits

(e.g., extraversion, neuroticism). Neuropsychologists study how brain operations control such processes and how this control breaks down due to brain dysfunction (e.g., physical trauma, stroke, infection, neurodegeneration) or psychological disorders (e.g., posttraumatic stress disorder, depression, schizophrenia).

Neuropsychology
The field of study that seeks to understand how brain processes make human behavior and psychological functions possible.

Clinical neuropsychologists become involved in the psychological and behavioral evaluation of individuals. By doing careful testing of a person's mental abilities and psychological functions, they can learn whether or not the person shows a pattern of impairments suggestive of brain damage, and if so, where in the brain the damage might be. Clinical neuropsychologists also help quantify the severity of psychological deficits by comparing a given person's performance to the average performance, or norms, established by the previous testing of many other people of similar educational, social, and cultural backgrounds (Werry, Daniel, & Bergström, 2019). Often, the pattern of deficits identified by neuropsychological testing may offer clues to the cause of brain damage. And by testing the same person at different times, neuropsychologists can detect whether a person's cognitive abilities are improving, worsening, or remaining stable. Clinical neuropsychologists may help to clarify how a person's problems from brain damage are likely to

affect that person’s ability to function socially, vocationally, and in other aspects of daily living. In addition, they can help formulate a regimen for rehabilitation and recovery from the effects of brain damage.

Clinical neuropsychologists must use several kinds of knowledge and skills in their work. First, as do other clinical psychologists, they make use of the interviewing, observation, and testing skills described in Chapters 3, 4, and 5. Thus, neuropsychological assessments consider the entire person, including social and family background, personality dynamics, and emotional reactions to possible brain dysfunction. Second, clinical neuropsychologists must be able to use specialized methods unique to neuropsychological assessment. Third, they must have knowledge of the neurosciences, including neuroanatomy (the study of nervous system structures and the connections between them), neurophysiology (the study of the functioning of the nervous system and its parts, including the chemistry of nerve tissue and the relationship between the nervous system and endocrine functions), and neuropharmacology (the study of how drugs affect nervous system functioning). Fourth, clinical neuropsychologists must know about a wide range of human cognitive abilities, including language and perception, and about how those abilities develop and change over time (e.g., behavioral genetics and life-span psychology). Fifth, neuropsychologists must be able to distinguish behavioral and psychological problems caused by brain dysfunction from those caused by psychopathology in structurally intact brains. Finally, neuropsychologists should be able to design effective rehabilitative programs based on an in-depth understanding of clinical psychology.

A Brief History of Neuropsychology

Section Preview Neuropsychology's roots go back to debates in the 1800s about brain organization and function. As case examples and new assessment techniques resolved many of these debates, a clearer understanding of neurological function and dysfunction led to the development of neuropsychology as a specialty within clinical psychology.

Neuropsychology includes topics that overlap with many areas of psychology, with experimental neuroscience, and with clinical neurology, but it has grown into a distinct field with unique investigation methods and treatment approaches. To understand modern neuropsychology, it is important to understand how it developed.

Early Influences

Neuropsychology emerged as a separate field of study during the mid-20th century, but its roots lie in two lines of 19th century thinking about the relationship between specific behaviors and specific areas of the brain (Tyler & Malessa, 2000). One point of view came from German anatomists Franz Gall and Johann Spurzheim, who in the 1830s described the concept of **localization of function**. According to this then-controversial view, different psychological functions are controlled by different brain areas. A similar view is largely accepted today, and Gall and Spurzheim would have been revered figures for proposing it had they not framed their ideas within a larger theory called *phrenology*. As noted in Chapter 1, phrenologists thought that individual differences in personality and intelligence could be assessed by mapping the bumps and indentations on the surface of the skull ("having your head examined"; see Figure 13.1). Phrenology was very popular with the public but disdained by most scientists because of the lack of evidence to support it. Unfortunately, once phrenology was discredited, so too was the concept of localization of function (Zola-Morgan, 1995).

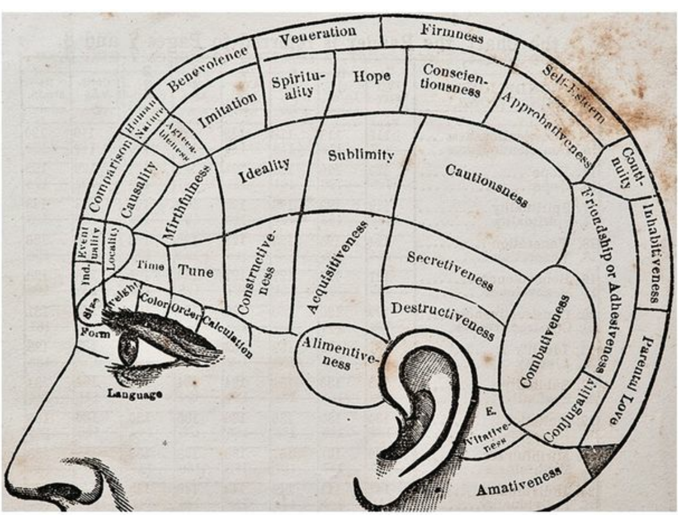

Figure 13.1 A Phrenological Map

Phrenologists claimed that each of 27 functions were localized in particular brain areas, and that if a person used particular functions more than others, the corresponding brain region would get larger and raise a bump on the skull above it.

(Source: VintageMedStock/Archive Photos/Getty Images.)

Localization of function

The view that different psychological functions are controlled by different brain areas.

An alternative line of thinking about brain and behavior suggested that no particular brain area was more important than any other for controlling a psychological function. Pierre Flourens (1794–1867), a widely respected French scientist, argued that his careful series of experiments supported that conclusion. He surgically destroyed parts of animals' brains and then observed the behavioral consequences. He concluded that although there was some localization of cortical function, the regions within the cerebral hemispheres functioned more like a single unit than a collection of specialized parts. This view was later supported by the work of Karl Lashley, who emphasized the capacity of one area of the cortex to take over for the functions of a destroyed area, a capacity he called **equipotentiality**.

Equipotentiality
The capacity of one area of the cortex to take over for the functions of a destroyed area.

Eventually, work in behavioral neurology convincingly showed that different areas of the brain, especially in the cerebral cortex, do indeed underlie different specific psychological functions. The pendulum began to swing back toward a localization of function position due to the work of a famous French surgeon, Paul Broca (1861, 1865), who discovered that expressive language (e.g., speech) depended on a particular part of the brain. Broca had the opportunity to confirm, by autopsy, that a patient with a profound speech problem but otherwise normal intelligence had damage to one small area of cortex in the left frontal lobe (circled in red in Figure 13.2).

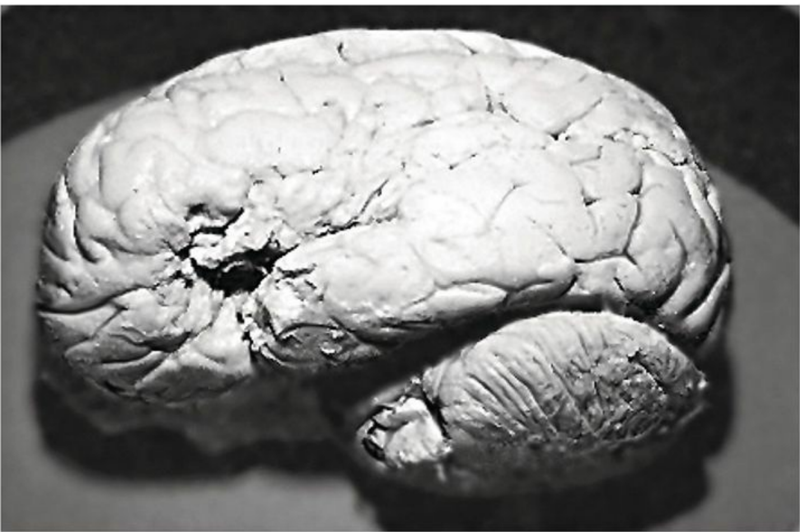

Figure 13.2 “Tan’s” Brain

> The patient whose brain Paul Broca examined was nicknamed “Tan” because that was the only word he could say clearly. Broca discovered severe damage in the left frontal lobe of the cerebral cortex, just in front of the primary motor cortex. Now called *Broca’s area*, it is involved with the ability to produce normal speech.
>
> (Source: ©2007, Oxford University Press.)

Broca’s esteemed reputation brought attention and legitimacy to the previously ridiculed idea of localization of brain function (Lorch, 2011). By 1863, he had collected a series of eight cases and used this evidence to argue so convincingly for localization of function that it became indisputable (Friedrich et al., 2019). Further support for localization of function came from the work of two Italian ophthalmologists: Antonio Quaglino and Giambattista Borelli. In 1867, they published a paper describing a man who developed *prosopagnosia*, the inability to recognize familiar faces, after suffering damage to the right hemisphere of his brain. Findings such as these made it clear that particular psychological functions are especially dependent on specific brain areas.

Development of Neuropsychological Assessment Techniques

As part of their evaluation of people, clinical neuropsychologists use standardized tests that assess separate aspects of psychological function. As described in Chapter 2, some of this testing tradition dates to the early 20th century, when French psychologist Alfred Binet had begun assessing children with brain damage. Tests such as his are usually associated with the beginning of modern intelligence testing (see Chapter 5), but they also laid the foundation for neuropsychological assessment. Many neuropsychological phenomena are commonly identified today using neuropsychological techniques that had been identified in Binet's time. These include *aphasia* (disordered language abilities), *apraxia* (impaired abilities to carry out learned purposeful movements), *agnosia* (disorders of perceptual recognition), and *amnesia* (disorders of memory). Although some influential psychologists relied on methods that emphasized a clinician's subjective impressions, several psychologists in the United States advocated using quantitative tests to measure different mental abilities in order to study how brain damage affects behavior (Eling, 2019).

One of these psychologists was Ward Halstead, who in 1935 founded a neuropsychology laboratory at the University of Chicago. His major contribution was to observe people with brain damage in natural settings. From these observations, he identified the key characteristics of behavior that should be assessed in any patient undergoing neuropsychological testing. After recording responses in many patients, Halstead compared their performance to control cases and identified 10 measures that could discriminate patients from controls (Reitan & Davison, 1974). His approach

was to use a *test battery*, a set of several different tests designed to complement each other to assess key categories of psychological function (e.g., language, memory, visual recognition). Halstead's first graduate student, Ralph Reitan, started a neuropsychology laboratory in 1951 at the Indiana University Medical Center. Reitan revised Halstead's test battery and included other measures in what came to be known as the *Halstead–Reitan Battery* (HRB). This battery is still widely used today.

Basic research in neuropsychology and advances in assessment methods grew dramatically following World War II, in part because of the need to assess many war-related cases of brain damage. A small number of prominent neuropsychologists developed and validated specific tests and test batteries (Jones & Butters, 1983), some of which were specifically designed to be used in special patient populations, such as people with traumatic brain injury. Others were aimed at assessing certain kinds of deficits, such as the loss of language function.

Split-Brain Research

Another important chapter in the history of neuropsychology is associated with the work of Roger Sperry and his colleagues at the California Institute of Technology (e.g., Sperry, 1961, 1968, 1982). They studied the effects in cats and monkeys of cutting the *corpus callosum*, the band of nerve pathways that allow the brain's two cerebral hemispheres to communicate directly with each other. This surgical procedure has also been done in humans, but rarely, and mainly in cases of severe epilepsy where drug treatment alone had failed. The procedure prevents the spread of seizures from one side of the brain to the other because, with the corpus callosum severed, the activity of one cerebral hemisphere proceeds largely isolated from that of the other hemisphere. Although vast sections of brain tissue devoted to complex information processing are rendered incommunicado by this surgery, differences between structurally intact people and so-called split-brain patients once seemed impossible to detect. But Sperry (who won the Nobel Prize in 1981 for his work) and his associates devised new experimental procedures to show how split brains were indeed different from intact ones (Pearce, 2019). His techniques showed how each cerebral hemisphere processed information in unique ways. Studying split-brain patients opened a new era in neuropsychology, because for the first time researchers could study the functioning of one large part of the brain in isolation from another large part, and thus better understand what each brain part contributes to a whole person's mental functioning.

Research on Normal Brains

Split-brain research, and the innovative testing techniques involved in it, stimulated an increase in studies of the organization of normal brains. Many of these studies used a *tachistoscope (*pronounced *"tah-KISS-tah-scope"),* a device that displays visual stimuli for a very brief period of time. When the eyes are fixated on a central point in the visual field, stimuli briefly flashed to the left of the fixation point are seen only in the left visual field. Similarly, stimuli briefly flashed to the right of the fixation point appear only in the right visual field. Because of the way the eyes are "wired" to the brain, information from the left side of space is sent first to the right cerebral hemisphere and information from the right side goes first to the left hemisphere. The information from each side of space is then normally shared between hemispheres via their connections through the pathways provided by the corpus callosum. Using tachistoscopic methods, experimenters directed the entry of visual stimuli into one hemisphere or the other and measured a person's accuracy of performance or reaction time in response. By measuring the relative accuracy of responses for the two visual fields, researchers have been able to document and confirm unique hemispheric superiorities for a wide variety of cognitive and perceptual tasks (Hellige, 2001).

More recently, neuropsychologists have found other ways to examine how the brain controls mental functions in normal human beings. For example, the advent of functional brain imaging methods (e.g., fMRI) has allowed cognitive neuroscientists to watch how different brain areas become more active or less active as a person engages in different tasks. Neuropsychologists play a vital part in this kind of research, because

functional imaging data can only shed light on the brain's control of mental life if the research participants are engaging in tasks whose psychological bases are well understood. By working to design tasks that isolate the use of specific mental functions, neuropsychologists make sure that functional brain imaging researchers know exactly which mental abilities they are studying (Sutterer & Tranel, 2017).

In Review A Brief History of Neuropsychology

Early influences	Clinical neuropsychology emerged as a distinct discipline only in the late-20th century, but its roots go back to 19th century efforts to understand brain organization and function.
Key events	Discovery that specific areas of the brain are differently specialized and help create different specific functions. Development of tests and test batteries to measure intellectual functioning and identify specific areas of normal and abnormal brain function. Study of split-brain patients allowed some brain areas to be assessed in isolation from each other. Development of techniques that provided normative information about the functioning of normal brains.

Test Yourself

1. ________________refers to the idea that various brain functions are controlled by particular parts of the brain.

2. _______________ is the idea that one area of the brain's cerebral cortex is able to take over the function of any other area of the cortex.

3. A "split-brain" patient is one whose ____________ has been severed.

You can find the answers in the Answer Key at the end of the book.

Basic Principles of Neuropsychology

Section Preview Here we provide some basic principles about how the brain works. Although various functions depend on somewhat compartmentalized brain areas, the various compartments or modules interact with each other in multiple ways. Each hemisphere has its specialties, but both hemispheres are involved in most tasks.

Understanding the principles of brain–behavior relationships that are fundamental to neuropsychology requires some understanding of the location and operation of the brain regions shown in Figure 13.3.

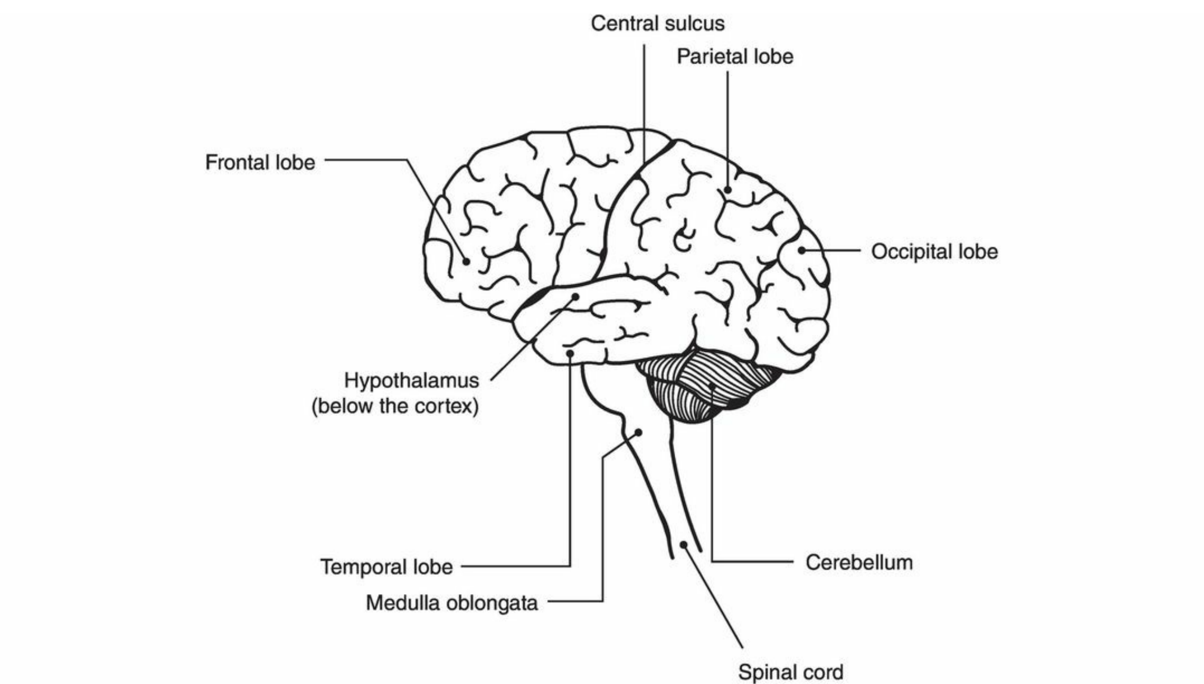

Figure 13.3 A Lateral View of the Human Cerebral Cortex and Other Brain Structures
The cortex is divided into four sections, or lobes, and many structures such as the hypothalamus, lie within it and underneath it.

A Modern View of Localization of Function

As already noted, the idea that different parts of the brain are involved in different specific behaviors and psychological functions became the prevailing view of scientists by the end of the 19th century (Tyler & Malessa, 2000). A modern version of this *localizationist* view is now well established. What is less clear is just what it is that is being localized to a given brain region and how different brain regions interact (Duffau, 2018).

Theorists who emphasize the interrelatedness of brain areas and who stress the holistic quality of brain functioning are sometimes known as *globalists*. John Hughlings Jackson, Karl Lashley, and Kurt Goldstein are three of the more influential globalists, but it was Russian neuropsychologist Alexander Luria who, more than any other scientist, explained brain organization by emphasizing its integration rather than its specificity (Glozman, 2007). Luria's theory was that the brain is organized into three functional systems: (a) a brain stem system for regulating a person's overall tone or waking state; (b) a system located in the posterior (back) portion of the cortex for obtaining, processing, and storing information received from the outside world; and (c) a system, located mainly in the anterior (front) portion of the cortex, for planning, regulating, and verifying mental operations. So, like other globalists, Luria believed that the brain engaged in some specialized "division of labor," but he emphasized the importance of understanding how these different brain areas work together.

Modules and Networks

Today, when neuropsychologists map the brain according to specific functions, they do so in a way that reflects both localizationist and globalist perspectives (Goldberg, 1995; Lezak, Howieson, & Loring, 2004). For example, the influential concept of *modularity* (Fodor, 1983) implies that different brain regions are unique in how they receive information, process that information, and then send the processed information to other brain regions. Different brain areas are thus seen as different information-processing modules, working across a widely dispersed network of modules, something like the many different circuit boards contained in a vast, complex computer. According to this view, a complicated psychological function such as attention is not "controlled" by a single brain area. Rather, attentional functions are seen to rely on several different brain modules, each adding a different piece to the puzzle, working together in an attention network that is distributed widely (Mesulam, 1990; Stam & van Straaten, 2012). Because different aspects of attention will rely more on one brain module than another, it follows that damage to a single module would affect one aspect of the attention network more than the others. It also follows that because a given module may provide a kind of information processing that several psychological function networks may each rely on, damage to that particular brain module could have consequences for each of those other networks and the psychological functions they subserve. And because many different modules may be involved in the network of brain areas associated with attention, damage in many different brain areas can affect attention.

Levels of Interaction

Different modules interact with each other to produce a seamless sequence of behaviors. The modules are organized in a fashion that reflects both the structure and function of the brain. Thus, you can think about the brain as having several levels of organization, ranging from the global to the local. For example, there are different functions associated with regions of the cerebral cortex on either side of the central sulcus shown in Figure 13.3. These functions can be distinguished by whether they primarily process *incoming* (sensory) information or program *outgoing* behavior (motor activity). In general, brain regions behind the central sulcus (toward the back of the brain) are more involved in the reception of sensory information (e.g., touch, pressure, temperature, and body position), whereas brain regions in front of the central sulcus are more involved in programming movement. But these brain regions are also organized in more specific ways. So, some sensory areas of cerebral cortex primarily process visual information while other areas primarily process auditory information (sound).

Lateralization of Function

The activity of each hemisphere of the cerebral cortex is associated with somewhat different functions. At one time, this difference was described in terms of "cerebral dominance," because the left hemisphere was seen as the "dominant" or "major" one and the right as the "nondominant" or "minor" hemisphere. Over time, this distinction was found to be misleading. Work by Sperry and others showed that different aspects of psychological life may be more dependent on one side of the brain than the other, but in most cases both sides of the brain are involved to some extent in most psychological functions. Thus, it is more appropriate to refer to a psychological function as being left or right "lateralized," but not "dominant."

Specialization of the Left Hemisphere. In most right-handed people, the left hemisphere is specialized to handle speech and other aspects of linguistic processing, such as the ability to understand what others say. The ability to speak a language is very strongly left lateralized in most right-handed people so that the right hemisphere has little or no direct control of speech. A similar brain organization is seen in left-handed people, but less consistently so (Strauss & Wada, 1983). Evidence that the left hemisphere is specialized for speech comes from a variety of sources. In addition to studies documenting language deficits in patients with left-hemisphere damage (Rasmussen & Milner, 1975), data from a number of neurosurgical procedures have provided comprehensive evidence for the left hemisphere's special language abilities. For example, before beginning a brain operation, neurosurgeons typically locate, and then try to avoid, regions of the brain that are crucial for language. One way that they do so is by electrically

stimulating particular areas of the brain to disrupt its usual information processing mechanisms. If this renders the patient unable to speak when instructed to, then those areas may be important for language. Such explorations have shown that stimulation of the left hemisphere, but usually not the right, leads to disruptions in speech production and language processing. Thus, stimulation of certain areas in the left temporal lobe disrupts verbal memory functions, whereas stimulation of some regions of the left frontal lobe disrupts speech production. Another technique for investigating language lateralization involves injecting sodium amytal into the internal carotid artery (Wada & Rasmussen, 1960). This *Wada task* (named for Juhn Wada, the Canadian neurologist who first conducted it) temporarily puts one hemisphere "to sleep," during which time the patient can be tested. When the left hemisphere is "sleeping," nearly all right-handed people lose their ability to speak (Milner, 1974; Wellmer et al., 2005).

Split-brain research has also provided powerful evidence for left lateralization of language functions. For example, patients with a severed corpus callosum might be asked to sit in front of a screen that makes it impossible to see objects placed in their hands (see Figure 13.4). To identify the object, the patients must depend entirely on touch information carried by sensory nerves extending from the hand to the brain. Like most nerve pathways, these sensory nerves cross over to send information to the opposite side of the brain, after which information processing can go to other areas in the cortex. As a result, information from the left hand initially arrives at the right parietal cortex (see Figure 13.3), and information from the right hand arrives at the left parietal cortex. In a normal brain, the corpus callosum transfers this information to the opposite hemisphere in a fraction of a second. In split-brain patients, because the corpus callosum is severed, the

only way their opposite hemisphere can obtain information about a touched object is if they look at it. But the screen blocks the patients' view, so what happens? These patients have no difficulty naming objects being held in the right hand (which is connected to their left hemisphere), but when asked to name objects held in the left hand (which is connected to the right hemisphere), the patients can usually not do so (e.g., Sperry, 1974).

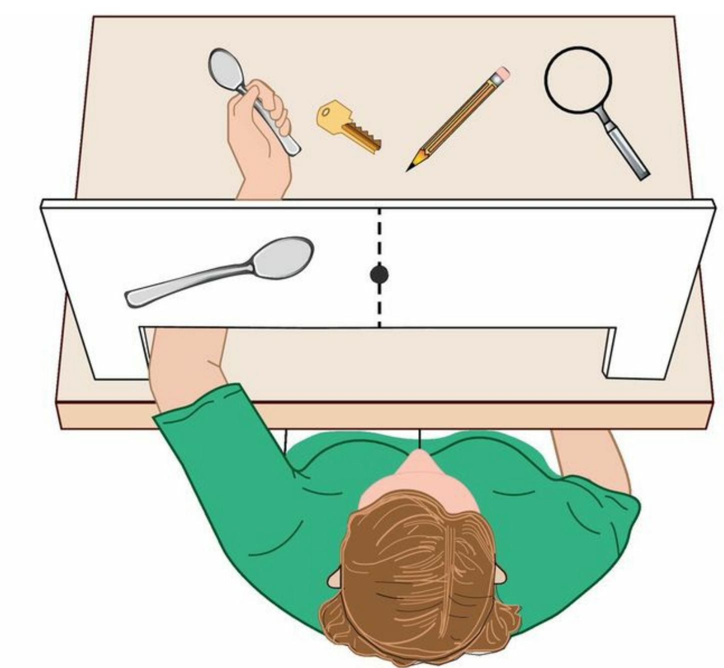

Figure 13.4 An Apparatus for Studying Split-Brain Patients

Sperry found that split-brain patients usually cannot name objects placed in their left hand, but that they can use their left hand (connected to the right hemisphere) to pick out the correct *picture* of the objects. This finding proved that the right hemisphere "knows" what the objects are but cannot label them verbally. The obvious conclusion is that the right hemisphere is mute—it has insufficient access to speech mechanisms controlled by the left hemisphere.

More recently, functional imaging studies of the brain have confirmed left lateralization of language functions. In these types of studies, an image of the brain shows where nerve cells are most active, or where blood tends to flow (Poldrak, 2018). The idea is that in brain areas more involved in a task, the nerve cells in those areas will use up more energy. By looking to see where nerve cells are most active, one can infer that the affected brain region may be involved in the information processing demands of the task. Such studies have confirmed what Wada tests would have predicted: when people are asked to perform linguistic tasks, left-hemisphere brain regions become more active and energy-demanding (Massot-Tarrús, Mousavi, & Mirsattari, 2017).

Specialization of the Right Hemisphere. Right-hemisphere function, too, has a role to play in language and communication, though it usually lacks the systems that allow people to speak. For example, people with right-hemisphere damage may have difficulty understanding the overall "point" of a paragraph, the plot of a story, or the punch line of a joke (Marini et al., 2005; Marinkovic et al., 2011). People with right-hemisphere damage also have difficulty understanding linguistic devices such as metaphors. As a result, they might interpret statements like "I cried my eyes out" as if they were literally true (Gardner et al., 1983).

In addition to supporting these aspects of language communication, right-hemisphere function is important for social communication (Patel et al., 2018). For example, the prosody of language, or the "tone of voice," appears to stem largely from right-hemisphere function. *Aprosodia*, an interruption in normal prosody functions, occurs after right-hemisphere damage more often than after left-hemisphere damage (Schirmer et al., 2001). A person with expressive aprosodia speaks in a monotone and sometimes must add a phrase

such as “I am angry” to allow the listener to understand the intended emotional message (Ghacibeh & Heilman, 2003). Those with receptive aprosodia, by contrast, may not pick up the sarcasm or anger in another person’s voice, which can lead to some rather unfortunate social misinterpretations.

As Sperry and his colleagues showed, if given a nonverbal means of communication, the right hemisphere is able to perform at a level of intelligence equal to that of the left. Indeed, one of the greatest contributions of split-brain research has been to remove the right hemisphere’s designation as the “minor” hemisphere and to demonstrate its capacity for high-level information processing. We now know that the right hemisphere is crucial for analyzing many types of spatial and nonverbal information, including the highly complex signals involved in social and emotional communication (Baird et al., 2006; Fournier et al., 2008; Najt, Bayer, & Hausmann, 2013). After all, only part of the most important information in a conversation is carried by the content of the utterances; a great deal of information is conveyed by *how* words are said. The right hemisphere is especially good at perceiving and decoding gestures, tone of voice, facial expressions, body language, and other nonverbal information, and then integrating them into a coherent message. Thus, right-hemisphere damage can sometimes cause dramatic dysfunctions in social communication (Tompkins, 2012).

Thinking Scientifically Can Someone Be Partially Paralyzed and Really Not Know It?

The difficulties patients with right-brain damage have in judging situations appropriately, in relating to others, and in accurately

perceiving social cues is often compounded by another problem—they are often unaware of their deficits. The inability to be aware of neurological problems is called *anosognosia* (Babinski, 1914), and it is more common after right-sided brain damage than left (Gainotti, 2019). Anosognosia poses a serious obstacle to rehabilitation programs because remedial strategies are less likely to be effective if patients do not perceive that they have a problem (Jenkinson, Preston, & Ellis, 2011). Even some people with severe paralysis caused by a right-hemisphere stroke do not appear to know that they have *hemiparesis*, a condition in which a person cannot move all or part of the left side of their body.

This seems hard to believe, though, and skeptics argue that people with anosognosia for hemiparesis are still fully capable of knowing that they are partially paralyzed but that this knowledge would be so upsetting that they simply cannot admit it, even to themselves. According to this argument, anosognosia is not true unawareness but an unconscious mental process similar to the ego defense mechanism that Freud called denial (see Chapter 8).

What am I being asked to believe?

Arguing against these skeptics are those who say that anosognosia occurs because the brain damage that causes hemiparesis also damages the brain areas that are needed in order to know that something is wrong (Piedimonte et al., 2016). As a result, patients who seem unaware of hemiparesis or other problems are, in fact, truly unaware of them (Heilman, 2014).

What kind of evidence is available to support the claim?

Those who believe that anosognosia is genuine unawareness argue that if it were due to an ego defense mechanism, patients should deny all potentially upsetting deficits. Yet some hemiparesis patients are aware that an arm is weak but not that a leg is weak (Berti, Ladavas, & Corti, 1996; Bisiach et al., 1986). Others are aware that they have a speech problem but not limb weakness (Bisiach et al., 1986; Breier et al., 1995), and some are aware of blindness but unaware of paralysis (Prigatano et al., 2011).

Another problem with the ego defense mechanism argument is the question of why anosognosia occurs more often after right-sided brain damage than after left-sided damage. Paralysis on either side of the body should be upsetting, and both should cause anosognosia according to the denial hypothesis. In fact, because most people are right-handed, weakness on the right side of the body (caused by left-side damage) should be even more upsetting and so more likely to result in psychologically motivated denial.

Additional evidence against the ego defense mechanism hypothesis comes from findings that anosognosia can occur even when there is no threat of permanent paralysis. When the right hemisphere is "turned off" using the Wada procedure mentioned earlier, normal participants became paralyzed in the left arm and leg. When asked about their experience, they recalled most details correctly, but most of them said that they did not notice any paralysis. When the left hemisphere was anesthetized, though, the patients not only became paralyzed on the right side but also later reported awareness of it. These data are hard to explain due to ego defense

mechanisms because after participants had recovered from their left-side paralysis, why would they be motivated to deny that it had occurred?

Are there alternative ways to interpret the evidence, including those that my biases and preconceptions might have kept me from seeing?

Some argue that Wada test results do not eliminate the motivated denial explanation for anosognosia (Turnbull, Fotopoulou, & Solms, 2014) because the test does not allow direct comparison of patient experiences during left- versus right-brain anesthesia. This is a fair point because speech areas are on the left side of the brain, meaning that people are usually unable to speak when their left hemisphere is "turned off." This doesn't happen on the right side. The only way to do a direct comparison of the experience of left- versus right-hemisphere inactivation is to ask questions after the anesthetic has worn off. If it were possible for patients to talk during left-hemisphere inactivation, perhaps they would show anosognosia because at that particular moment, there could be enough distress to motivate denial.

The psychological denial interpretation is supported by research decades ago in patients whose strokes caused hemiparesis (Weinstein & Kahn, 1955). When their families were interviewed, those patients who, before their stroke, had tended to cope with stress through denial were also the ones most likely to deny their hemiparesis. Patients who did not show anosognosia were described by their families as less likely to have previously used denial as a coping strategy. These data implied that denial of hemiparesis could be an

exaggeration of typical stress-coping tendencies. In addition, patients who deny paralysis sometimes show implicit awareness of it, such as by changing the way they walk after one leg becomes weak or paralyzed (Mograbi & Morris, 2013). Further, their denial may wax and wane over time. Some argue from such observations that, at some level, these patients "know" they are paralyzed, even if the awareness is not conscious. However, unconscious "awareness" of deficits does not prove that psychological denial is operating. It may merely be another example of the fact that some of the brain systems that monitor body functions operate at an unconscious or nonconscious level (Prigatano, 2013).

What additional evidence would help evaluate the alternatives?

One problem with research on anosognosia is that different studies have used different criteria for diagnosing anosognosia. A standardized system for detecting anosognosia would be of great value in ensuring that all researchers are using the same "yardstick" (e.g., Turró-Garriga et al., 2014).

A better way of assessing a patient's previous coping strategies would help, too. Family members' reports about how a patient typically coped with stress may suffer from retrospective bias. That is, if family members know that the patient is denying hemiparesis, they might be more likely to recall similar episodes of denial in the relative's past and fail to recall times when the patient coped with stress in other ways.

One way around the problem of retrospective bias would be to do a prospective study in which a large group of individuals is

identified, their typical stress-coping tendencies are assessed, and then they are contacted on a regular basis for many years. The ego defense mechanism hypothesis would be supported in such a study if the people in the group who were most likely to use denial as a coping mechanism are also the ones most likely to display anosognosia following a stroke.

What conclusions are most reasonable given the kind of evidence available?

Some individuals who suffer neurological deficits probably do use denial or other psychological defense mechanisms to avoid facing distress, but the bulk of scientific evidence suggests that most cases of anosognosia reflect a true lack of awareness of neurological deficit.

In Review Basic Principles of Neuropsychology

<table>
<tr><td>From localization of function, to modules, to networks</td><td>Brain functions are localized in different regions, but they are not entirely compartmentalized.
Modules that specialize in certain functions interact with other modules that may process information differently.
Networks of modules are connected at multiple levels, so damage to one area may result in impairment of only certain aspects of a particular mental function.</td></tr>
<tr><td>Laterality</td><td>Damage to the left versus the right cerebral hemisphere often results in different specific patterns of cognitive, socioemotional, or behavioral deficits.</td></tr>
<tr><td colspan="2">Test Yourself

1. Because the brain is organized in _______, a single brain area can participate in more than one kind of psychological function or mental ability.

2. The left cerebral hemisphere is lateralized for ______________

3. As a result of a stroke, one side of a patient’s body is completely paralyzed but the patient is completely unaware of this. On which side of the brain did the stroke probably occur?

You can find the answers in the Answer Key at the end of the book.</td></tr>
</table>

Patterns of Neuropsychological Dysfunction

Section Preview Injuries to specific parts of the brain are associated with particular kinds of psychological problems. Here we describe some behavioral manifestations of brain dysfunction, first organized by the regions, or lobes, in which the damage occurred, and concluding with some common syndromes associated with more widespread brain damage.

Occipital Lobe Dysfunction

Visual information is sent from the retina in each eye to the thalamus and then to the *occipital lobes* of the cerebral cortex (see Figure 13.3). At each step along the way, this information is represented *topographically*; in other words, neighboring nerve cells respond to neighboring areas of the visual field. There are similar arrangements for other types of sensory information.

The most common problem caused by damage to the occipital lobe is blindness. Because about half of the retinal fibers coming from each eye cross over to the opposite side as they enter the brain, damage to one occipital lobe produces blindness in the opposite visual field. For example, damage to the right occipital lobe causes blindness in the left visual field, but neuropsychologists have shown that some people continue to process a certain amount of visual information. This phenomenon, called *blindsight*, can occur because some visual information processing occurs outside of the visual cortex (Cowey, 2010b), but without conscious awareness. So people with blindsight may duck when an object flies rapidly toward their head but not know why they have done so. Or, they may be able to guess the color of an object in front of them, even though they are unaware of seeing it (Cowey, 2010a).

Sometimes, occipital lobe damage alters visual perception instead of blocking it. For example, in a condition called *palinopsia*, a person will experience the image of an object for up to several minutes after the object has been taken away (Gersztenkorn & Lee, 2015). Apparently, the brain regions involved in processing the visual information develop a kind of reverberating circuit that does not shut off when it should.

Parietal Lobe Dysfunction

As suggested by the blindsight phenomenon, after visual information is received and processed in the occipital lobes, it is relayed to nearby cortical areas in the posterior (back) superior (top) parts of the *parietal lobes*. These areas are classified as "association" cortex because they do not receive sensory information directly from sense organs, nor do they directly send movement commands to muscles; instead, they interact mainly with other cortical areas to combine and integrate information from multiple cortical modules.

Parietal association cortex is thus a meeting ground for visual, auditory, and other sensory input, making it a vital area for creating a unified perception of the world. In particular, areas of the parietal lobes help create a map of our environment and the objects in it; they also perform an ongoing analysis of where objects are in our sensory world, and how they are moving. Because of this specialty, cortical parietal regions play a unique role in attention and awareness of spatial location (Ungerleider & Mishkin, 1982).

Patients with damage to the parietal lobe on only one side of the brain often display an intriguing deficit called *hemineglect* in which they ignore the side of the body and the side of space opposite the damaged hemisphere (Langer, Piechowski-Jozwiak, & Bogousslavsky, 2019). Thus, people with damage in the right parietal region might not eat the food on the left side of their plates, or they might forget to comb the hair on the left side of their heads, or fail to button their left shirtsleeve. They might also ignore words on the left side of a page and fail to notice when someone approaches from their left. They may even fail to notice the left side of scenes that they imagine in

their head (Bisiach, Luzzatti, & Perani, 1979). Hemineglect can be so extreme in some patients that they may believe that parts of their bodies belong to other people. Neurologist Oliver Sacks (1990) described a patient who woke up in the middle of the night and tried to throw his leg out of bed because he thought that it belonged to an invading stranger. The hemineglect syndrome is most common after damage to regions of the right parietal lobe (probably because of the unique specialization of the right hemisphere for processing spatial information), but it can occur after damage to the left parietal lobe as well.

One way in which clinical neuropsychologists test for hemineglect is to ask a patient to draw a clock or a flower. People with hemineglect may draw all the numbers on the clock, or all the details of the flower, on half of the paper and leave the other half blank. Other tests of hemineglect include tasks in which individuals try to cross out all of the letters or symbols on a page or try to mark the midpoint of a line. People with hemineglect may fail to cross out items on the neglected side, or they may mark the line off-center, as if part of the neglected side of the line did not exist.

Another possible consequence of parietal lobe dysfunction, especially on the right side of the brain, is *simultanagnosia* (Chechlacz et al., 2012). Patients with this problem can see, but they have difficulty grouping items together in space. In essence, they can see the trees, but not the forest. Clinical neuropsychologists typically assess the presence of such parietal lobe deficits by using tests of visuospatial skills. For example, they present patients with “global–local” stimuli (Navon, 1983) such as the one shown in Figure 13.5.

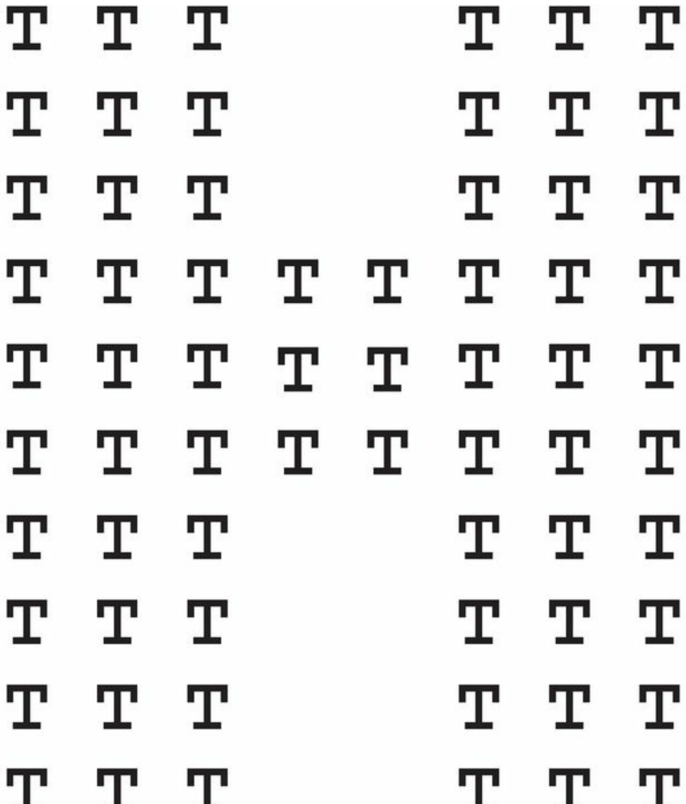

Figure 13.5 A “Global–Local” Stimulus for Testing Patients for Simultanagnosia

Patients with simultanagnosia are typically able to see the individual parts of a display like this but cannot put them together to see the “big picture” those parts create.

Here is how one simultanagnosia patient responded when she looked at that figure (Shenker & Roberts, 2016):

EXAMINER: What do you see?

PATIENT: I see T, T, T, T… . Do I keep going?

EXAMINER: Anything else?

PATIENT: T, T, T, T … lots of Ts.

EXAMINER: Are there any other letters?

PATIENT: No.

EXAMINER: Is there an H?

PATIENT: No, just Ts.

EXAMINER: Is there a big letter?

PATIENT: No, I don’t see one.

EXAMINER: Is there a big letter H?

PATIENT: No.

EXAMINER: Do the little letters together form the shape of a big letter H?

PATIENT: I don’t see how.

EXAMINER: (Outlines the H with finger) Do you see how this is a big H?

PATIENT: I don’t see an H.

Temporal Lobe Dysfunction

While incoming visual information is being integrated in the parietal lobes, that same information is also being analyzed in cortical areas of the *temporal lobe* (Barton, 2011). This additional analysis in cortical modules in the posterior and inferior (underneath) temporal lobes allows a person to recognize what they see. If these areas are damaged, the person can still see the objects, but might not be able to recognize what they are (Behrmann et al., 2016). So when people with this problem, called *visual agnosia*, look at an apple, they might describe it as "a rounded smooth spherical object with a thin protrusion at the top" but be unable to name it, say what it is used for, where it can be found, and so on.

Because visual agnosia is caused by problems that affect only visual pathways, these patients may instantly recognize and name objects if they are allowed to touch or smell them, for example. In other words, posterior inferior temporal lobe damage disrupts the ability to extract the identity of objects from visual sensations but does not destroy the more general understanding of what those objects are, nor does it impair the ability to recognize those objects via input from other sensory modalities. Some forms of agnosia can be amazingly specific to particular dimensions of the visual world. For example, patients may lose the ability to recognize trees, dogs, and other living things, yet retain the ability to recognize cups, books, and other inanimate objects (Wolk, Coslett, & Gloser, 2005). Such dissociations suggest that the brain honors a distinction between highly specific categories of knowledge, a clinical observation that has prompted further study by cognitive scientists.

Parts of the temporal lobes also play roles in other psychological functions, such as processing of auditory information. There are specialized areas of auditory cortex in the temporal lobes that contribute to our ability to receive and make sense of the language we hear. As you would expect from split-brain research and studies of laterality in structurally intact people, these language modules of the temporal lobe are usually on the left side of the brain.

Other temporal lobe brain structures are involved in other functions —especially memory. Indeed, some of the most dramatic effects of temporal lobe damage can appear as disruptions of memory. For example, anterior (front) and medial (toward the inside) temporal lobe structures are critical for our ability to transfer information into long-term memory storage throughout the brain. So when infections like herpes encephalitis damage the medial temporal lobe and its connections to other brain regions, people may develop a permanent amnesia syndrome dominated by difficulty in forming new memories (Grydeland et al., 2010). And, when medical conditions require surgery to remove the *hippocampus* from both medial temporal lobes, these patients often become unable to form new long-term memories (Lee, Brodersen, & Rudebeck, 2013; Scoville & Milner, 1957). In such people, every event, no matter how often repeated, feels as if it is happening for the first time. These people cannot recall previous conversations, nor can they remember the name of someone they met minutes ago. This memory loss is most evident on a conscious level; that is, these amnestic patients may not be *explicitly* aware of having seen a particular object in the past. However, their responses to that object sometimes show that they have an unconscious, or *implicit* memory, of having seen it before (Dew & Cabeza, 2011). The effect of this implicit memory can be seen when a patient shows improved

performance after repeated practice with a puzzle task (Verfaellie & Keane, 1997), differing patterns of eye movements when looking at previously seen versus never seen pictures (Mednick et al., 2009), or changes in heart rate or skin conduction in response to familiar versus unfamiliar stimuli (Gazzaniga, Fendrich, & Wessinger, 1994; Jacoby & Kelley, 1987; Milner & Rugg, 1992).

Some temporal lobe structures may also be important in attaching emotional or motivational significance to stimuli and events (McGaugh, 2006). People with *temporal lobe epilepsy* (TLE), for example, may display a collection of emotional traits, which some have called the “TLE personality” (Bear & Fedio, 1977). One of these traits is a tendency to see mundane events as imbued with grand personal emotional significance, a tendency that can lead to magical or sometimes paranoid thinking. Patients with TLE personality also display *hypergraphia*, a tendency to do a lot of writing and take a lot of notes, and they may also be slow to pick up on social cues. This last trait can make them socially “sticky,” meaning that it is difficult to gracefully end a conversation with them.

Clinical neuropsychologists often assess problems associated with temporal lobe pathology by using memory tests such as *Benton’s Visual Retention Test*, the *Wechsler Memory Scale*, and the *California Verbal Learning Test*. They also compare patients’ memory for verbal material, reflective of left temporal lobe function, with their memory for visuospatial material, reflective of right temporal lobe function.

Frontal Lobe Dysfunction

As we saw in the case of “Tan,” the patient described by Paul Broca, people with damage to the left *frontal lobe* have language problems, especially being able to speak. In fact, this patient got his nickname because “tan” was the only word he could say. But many areas in both frontal lobes are involved in other functions, including the ability to plan. This kind of activity is part of what is sometimes called the *executive function* of the brain, because, like the work of a corporate executive, it entails organizing, supervising, sorting, strategizing, anticipating, planning, making judgments and decisions, engaging in self-regulation, assimilating new information, adapting to novel situations, and taking purposeful action (DeRight, 2019). As befits a position of such responsibility, the frontal lobes have lots of association cortex and receive input from almost all other parts of the brain. This input is necessary because making appropriate decisions about responses and actions requires taking into account as much current information as possible from the outside world and from the rest of the body. The frontal lobes can thus compare new information to previous information, assess its motivational and affective significance, and create appropriate sequences of responses.

No wonder, then, that damage to the frontal lobes can profoundly affect social and emotional functioning. These effects were clear in the famous case of Phineas Gage (Neylan, 1999), a Vermont railroad worker who, in 1848, suffered frontal lobe damage when an explosion sent a steel rod through his skull, piercing his frontal lobes (see Figure 13.6). Amazingly, he survived this trauma with his speech, movements, and overall intelligence apparently intact, but his personality changed. Once a responsible, judicious, and

socially adept fellow, he became loud and profane, blurted out inappropriate comments, made poor decisions, and did not follow through with plans. It was said, that "Gage was no longer Gage" (Harlow, 1848), but he seemed oblivious to these changes. Actually, Gage had more than just frontal lobe damage; he also had a brain infection and multiple seizures, making interpretation of the cause of his personality changes less clear. Nevertheless, his case drew media attention at the time, and remains a sensational story even today.

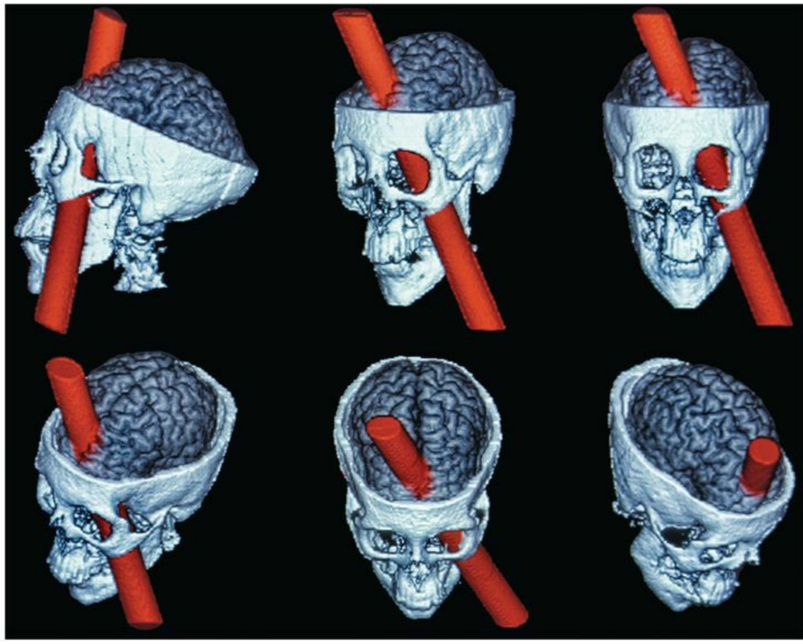

Figure 13.6 Digitally Remastered Images Based on the Skull of Phineas Gage

These images show the route of passage and the extent of brain damage occurring when a 3 foot 7 inch, 1.25 inch diameter rod shot through Gage's head on September 13, 1848.

(Source: Patrick Landmann/Science Source.)

People with frontal lobe damage may show deficits in planning and organizing the various components of a cognitive task, but not necessarily with the components themselves. In one case, a patient's performance on multiple neuropsychological tests was unimpaired, yet he was unable to hold down a job, do household chores, or even decide what to do next (Eslinger & Damasio, 1985). Despite wholly intact perceptual abilities and intellectual skills, he was unable to integrate all the information available to him and apply it to daily activities in an adaptive fashion. These individuals may also have problems performing goal-directed behavior. For example, when cooking a meal, they may fail to break the task down into its necessary steps, may misplan how to do each step, may mistime each step, or may not make proper adjustments—as when something starts to burn.

The problems in planning and organization created by frontal lobe damage can take curious forms. Consider, for a moment, what would happen if you suddenly found it difficult to plan what to say, do, feel, or think next? Would you simply do the same thing over and over, rather than "plan" something new? This is called *perseveration*, and it causes a patient to say or think or do the same thing repeatedly. It is often hard to steer the conversation onto a new topic with such people. If you couldn't plan what to say or do next, maybe you would rely on the convenience of copying words or actions from your environment. Some frontal lobe patients do simply imitate the words others say (*echolalia*) or the actions they see others do (*echopraxia*). Or perhaps you would find it so hard to plan actions and thoughts that you would just not do much at all. Indeed, some frontal lobe patients display *abulia*, a reluctance to move, speak, or initiate interactions (Marin & Wilkosz, 2005). Abulic individuals appear withdrawn and unmotivated. In mild cases of abulia, patients merely show little variety in

what they say or do. In extreme cases, they may display *akinetic mutism:* they literally never move or speak. (Table 13.1 summarizes some of the many kinds of neuropsychological dysfunctions presented in this section.)

Table 13.1 A Sampling of Neuropsychological Dysfunctions

Dysfunction	Prominent Symptom
Aphasia	Disordered language abilities
Apraxia	Impaired ability to carry out learned purposeful movements
Agnosia	Disorders of perceptual recognition
Prosopagnosia	Inability to recognize faces
Amnesia	Disorders of memory
Aprosodia	An interruption in normal prosody (tone of voice) functions
Anosognosia	Inability to be aware of neurological problems
Hemineglect	Ignoring the side of the body and the side of space opposite the damaged hemisphere
Echolalia	Repeating the words someone else has just said
Echopraxia	Repeating the movements someone else has just done
Akinetic mutism	Never moving or speaking
Blindsight	Having no conscious awareness of seeing and yet responding to visual stimuli as if they were seen

Palinopsia	The experience of having the visual experience of seeing an image after it has been removed
Simultanagnosia	Ability to see but difficulty grouping seen items together in space

It can be difficult to identify deficits in executive functioning using neuropsychological tests. The testing process usually includes tasks requiring a person to identify and act on temporal sequences, to plan and then revise strategies, or to solve problems whose demands change over time (Goldberg & Bougakov, 2005). Two tests commonly used to assess frontal lobe damage are the *Wisconsin Card Sorting Test* and the *Categories Test* from the Halstead–Reitan Battery. Both tests use feedback from the examiner to tell patients whether they were right or wrong on each trial. This feedback is designed to signal when it is time to change unsuccessful strategies when matching or categorizing information. Patients with frontal lobe lesions will often cling to the same strategy even if it is unsuccessful.

Neuropsychological Syndromes

Even when there is damage to large areas of the brain rather than just to one lobe or one side, some regions may be affected more, or differently, than others, and thus alter specific psychological functions in specific ways. The medical conditions that can cause such widespread brain damage may do so in a more or less consistent way, creating recognizable patterns—or *syndromes*—of change in psychological functions and cognitive abilities. Neuropsychologists have helped establish which syndromes are associated with each medical problem, thus making it easier to diagnose those problems.

Try this To get a quick idea of how they do this, stop reading and open the timer on your phone or other device, and then count the number of unique words starting with *F* you can say in 1 minute. Now count the number of animals you can name in a minute. Which of these tasks is easier for you? Read on to see how tasks like these are sometimes used by neuropsychologists to test for the presence of neuropsychological syndromes.

One of the most common examples of a neuropsychological syndrome is **dementia**, known officially in the DSM-5 as *major neurocognitive disorder*. Dementia is not an inevitable part of "getting old." It is defined by neuropsychologists as an ongoing decline from a person's previous baseline in more than one domain of mental ability that is severe enough to disrupt a person's ability to function on a day-to-day basis. The most common cause of dementia is Alzheimer's disease, but evidence from autopsies shows that it can also be caused by other problems, such as Lewy body disease, frontotemporal degeneration (FTD), vascular dementia, hippocampal sclerosis (Barker et al., 2002), and a recently discovered disorder called

limbic-predominant, age-related TDP-43 encephalopathy, known as LATE (Nelson et al., 2019). Because these diseases cause widespread brain damage, you might think that everyone with dementia would display the same syndrome of deficits, but careful neuropsychological testing shows otherwise. For example, in contrast to other dementias, the dementia seen in Alzheimer's patients often involves a greater loss of "category fluency" (which can be assessed by counting how many animals a person can name in 1 minute) than of "verbal fluency" (which can be assessed by giving them 1 minute to say as many words as possible that start with *F*). Most normal people, and even those with some forms of dementia, are better at category fluency than verbal fluency, but in Alzheimer's disease, this difference is often reversed (Mirandez et al., 2017). The results of these and other kinds of testing help clinical neuropsychologists know when a dementia is caused by Alzheimer's disease rather than by other diseases (Bondi, Edmonds, & Salmon, 2017).

Dementia
An ongoing decline in more than one domain of mental ability severe enough to disrupt daily functioning.

In Chapter 3, we mentioned that Rachel Jackson's grandmother, Danutė Bagdonas, was referred to Dr. Geoffrey Kramer, a clinical neuropsychologist, after showing signs of confusion, forgetfulness, and repeating herself more than usual. Once, she walked away from a boiling pot on a stove and forgot

to come back to it. Her already marginal English language skills have been declining, and she is using Lithuanian or Russian words more than usual to try to get her points across. Nevertheless, Dr. Kramer was able to conduct a fairly detailed clinical interview with Mrs. Bagdonas, as well as her daughter, Lena. He then spent a few hours testing Mrs. Bagdonas using a battery of standard neuropsychological measures. Because the testing was done in English, before interpreting the results, Dr. Kramer looked up published norms to determine the averages expected for people who are not native English speakers. Even so, on several measures, Mrs. Bagdonas's scores were more than two standard deviations below expected averages.

Dr. Kramer concluded that Mrs. Bagdonas had dementia and that the pattern of test results suggested Alzheimer's disease as the most likely cause. He presented this information to the family's physician who used this information to prescribe medication and give advice about what to expect. Lena wanted her mother to remain as independent as possible "to preserve her dignity," but citing medical ethics, dementia guidelines, and safety risks, the physician recommended that Mrs. Bagdonas should stop driving and should not be left at home alone (Doody et al., 2001; Iverson et al., 2010).

Mrs. Bagdonas's case illustrates circumstances in which a dementia-causing disease has already damaged the brain to the point that it may be unsafe for her to drive or live alone. But this is not true in every case, so exactly where is that point, and how can it be best diagnosed (Atri, 2019)? Most dementia-causing diseases develop slowly in a decades-long *preclinical stage*, with no obvious symptoms (Sperling et al., 2011). This is why researchers are trying to develop "biomarkers," physiological measures such as special brain scans, spinal fluid tests, and blood tests that can warn that a dementia-causing disease is developing. These tests are getting better, but

they are far from perfect, so some physicians and neuropsychologists struggle with the ethics of telling patients that they *may* have a potentially devastating disease, decades before its symptoms would appear. Add the fact that biomarker tests are often not covered by medical insurance plans, that a test result suggesting future illness is likely to cause (possibly needless) worry, and that there are still no medications that can stop the development of dementia-causing diseases, and you can see why biomarkers stir up controversy in the medical and neuropsychological communities (Vanderschaeghe, Dierickx, & Vandenberghe, 2018).

Some argue that a better approach may be to use simple, quick neuropsychology screenings to detect subtle cognitive changes at the earliest onset of symptoms (Mortamais et al., 2017). If needed, such screenings would then be followed by full neuropsychological evaluations, thus making it likely that symptomatic dementia-causing diseases can be detected as soon as their effects begin to appear.

In Review Patterns of Neuropsychological Dysfunction

Occipital lobe damage	Likely to affect some aspects of vision.
Parietal lobe damage	May affect attention or awareness of spatial location.
Temporal lobe damage	May affect some aspects of understanding language, ability to perceive and recognize objects, or ability to form new memories.
Frontal lobe damage	May affect speaking, emotionality, and executive functions such as planning and impulse control.
Neuropsychological syndromes	Brain dysfunction that occurs over many brain regions, not just one lobe. They result in patterns of neuropsychology test results that are specific enough to make them diagnosable.

Test Yourself

1. A person with ___________ can no longer recognize faces.

2. After frontal lobe brain damage, loss of ___________ may cause difficulty with planning, impulse control, and judgment.

3. ______ is defined as a notable decline in cognitive functioning severe enough to interfere with a person’s ability to function normally on a day-to-day basis.

You can find the answers in the Answer Key at the end of the book.

Neuropsychological Assessment

Section Preview As illustrated in the previous section, clinical neuropsychologists' efforts to identify the symptoms and locations of brain damage and to plan rehabilitative interventions always begin with assessment. It can involve standardized batteries or tests specifically selected for individual patients. Because clinical neuropsychologists often work with physicians, they must be familiar with a wide range of medical and neurological assessment techniques.

One of the first steps clinical neuropsychologists take in dealing with patients is to assess their cognitive, emotional, and behavioral functioning. Assessment is designed to: (a) establish the nature and severity of a patient's deficits; (b) determine the likelihood that the deficits stem from brain damage; (c) provide an educated guess as to where the damage might be located; and (d) identify the particular disease or the kind of damage responsible for the particular pattern of deficits seen. A *deficit* is defined as unusually poor task performance in comparison with appropriately selected norms derived from healthy, average people. When possible, the neuropsychologist will compare a patient's current performance with earlier ones in order to detect emerging deficits (or improvements). As in the case of Danutė Bagdonas, the clinical neuropsychologist will also conduct a thorough interview and examine the patient's medical records, including records of previous assessments. Information about *premorbid* (before-disorder) functioning, demographic, familial, linguistic, and educational history allows the clinician to place the current levels of functioning in a

historical context. This kind of consideration was important in Mrs. Bagdonas's case, because her early upbringing in Lithuania meant that her neuropsychology test performance had to be interpreted in light of a correctly selected set of norms. Testing Mrs. Bagdonas in the future may yield information about how rapidly her apparent Alzheimer's disease is progressing, and whether other disease processes may be emerging.

Clinical neuropsychologists typically follow one of two approaches to assessment. The first is to use the same predetermined, standardized battery of tests with all patients. As described earlier, these test batteries are comprehensive, and their standardization is useful for research. Further, because there is no need for expert judgments about what tests to use, these batteries can be administered by paraprofessionals. Test batteries can be inefficient, though, because they may require assessing functions not even alleged to be impaired. Also, the standardized approach makes it difficult to examine an unusual complaint or finding that may affect a particular individual. Batteries may also become obsolete, because it is difficult to revise them to incorporate new and potentially improved tests.

The second approach to neuropsychological assessment is the *individualized method* in which an opening round of tests is routinely given to every patient, but the choice of other tests is based on the results of the first set and is tailored to answer specific diagnostic questions that are of greatest interest. Individualized approaches allow in-depth assessment of particular problems, permit the use of new tests as they are developed, and focus more intensely on the specific difficulties that are most relevant for a given patient. One disadvantage of individualized approaches is that they require testers to have the advanced neuropsychology training necessary to know which diagnostic hypotheses to test and which tests will provide the information

needed to confirm or disconfirm those hypotheses. Also, because different combinations of tests are used with different people, individualized testing data are less useful to researchers interested in making comparisons across patients.

Neuropsychological Test Batteries

One widely used battery approach to neuropsychological assessment in the United States is exemplified by the Halstead–Reitan Battery, or HRB (see Table 13.2). It is suitable for patients aged 15 and older, but there are two other versions for children aged between 5 and 8 and between 9 to 14 years. Many examiners who use the HRB also administer a Wechsler Intelligence Scale, tests of memory, and personality tests such as the MMPI-2 (Reitan & Wolfson, 2009; see Chapter 5).

Table 13.2 The Halstead–Reitan Neurological Test Battery

The tests listed here make up the core of the HRB

Test Name	Designed to Measure
Categories Test	Mental efficiency, ability to derive a rule from experience, and ability to form abstract concepts.
Tactual Performance Test	Abilities such as motor speed, tactile and kinesthetic perception, and incidental memory.
Seashore Rhythm Test	Nonverbal auditory perception, attention, and concentration.
Speech-Sounds Perception Test	Language processing, verbal auditory perception, attention, and concentration.
Finger Oscillation or Finger Tapping Test	Motor speed.
Trail-Making Test	Visual scanning, cognitive sequencing, and executive function.

Dynamometer or Strength of Grip Test	Right- versus left-side comparison of physical strength.
Sensory-Perceptual Exam	Whether the patient can perceive sensory information separately and with standard variations in the location of the stimulation used.
Tactile Perception Tests	Tactile perception.
Aphasia Screening Test	Several aspects of language usage and recognition.

The HRB evaluates four aspects of patients' performance. First, *level of performance* is assessed by comparing the patient's performance to that of normative groups; an impairment index is calculated according to the number of tests for which the patient's performance falls into a clinically deficient range. Second, *patterns of performance* are analyzed. Pattern analysis examines variations in performance on different components of a test. Third, *comparing right-side to left-side performance* allows the neuropsychologist to draw inferences about hemispheric functioning when large differences appear. Fourth, *pathognomonic signs* are identified. These are deficits that are so strongly and specifically indicative of a disorder that their presence very often establishes a diagnosis.

The established form of the HRB and a newer expanded version have each shown good validity in discriminating patients with brain damage from healthy, undamaged people (Loring & Larrabee, 2006; Patt et al., 2018). The battery has also demonstrated good validity in detecting the lateralization and localization (Reitan, 1964) of brain damage, but it does a relatively poor job

of discriminating between brain damage and serious psychological disorders such as schizophrenia (Jones & Butters, 1983; Ross, Allen, & Goldstein, 2013).

Another battery of tests is based on the work of Alexander Luria, the Russian neuropsychologist mentioned earlier who developed assessment instruments for use with brain-injured veterans of World War II (Luria, 1962). Created in the late 1970s by the American clinical neuropsychologist Charles Golden (Golden, Purisch, & Hammeke, 1979), the *Luria–Nebraska Neuropsychological Battery* has been said to be capable of discriminating patients with brain injury from those with schizophrenia. However, this battery has been severely criticized for flawed test construction, improper data analysis, inadequate standardization, and a distortion of Luria's original methods, which simply may not be translatable into items on a battery (see Lezak, Howieson, & Loring, 2004, for a review of these criticisms).

Individualized Approaches to Neuropsychological Testing

One of the most thorough and best-described individualized approaches has been that of Muriel D. Lezak, a psychologist at the Oregon Health Sciences University and the Portland, Oregon, Veterans Administration Hospital. Clinical neuropsychologists using Lezak's strategy (Lezak, Howieson, & Loring, 2004) give all patients several standard tests that assess major functions in the auditory and visual receptive modalities as well as in the spoken, written, graphic, and constructional response modalities. Following this initial battery, which usually takes 2 to 3 hours, the neuropsychologist proceeds with "hypothesis testing," during which the assessment shifts its focus from one set of functions to another as tests indicate what abilities may be most impaired.

It is difficult to assess the validity of individualized approaches because they are tailored to each patient's needs and hence are not given in exactly the same form to sufficient numbers of patients to permit large-scale comparisons. And because individualized approaches depend much more than batteries do on the skill of the examiner using them, it becomes difficult to separate the validity of the tests from the level of that clinical skill. Perhaps for these reasons, there is some judicial precedent for using only test battery approaches in court cases (Bigler, 2007). Despite their limitations, individualized approaches can sometimes provide adequate construct validity and may be a useful way of obtaining the most personalized assessment of a patient (e.g., Coughlan et al., 2019).

Neuropsychological Assessment and Rehabilitation

Neuropsychological assessment of mental functioning has long been central to planning rehabilitation programs following brain injuries (Magnin et al., 2019). By carefully measuring and precisely characterizing the ways in which mental functions have been affected by such injuries, neuropsychologists help determine which functions should be the targets of rehabilitation efforts. Repeated neuropsychological assessments can also serve to help measure the effects of those efforts (Cicernone et al, 2019; Johnson-Greene, 2018).

Neuroplasticity. Rehabilitation efforts are often aided by the fact that the behavioral and cognitive impairments that follow brain damage may improve to some extent as time passes. Some of this improvement occurs through physical healing of damaged brain tissue, but it can also be due to **neuroplasticity**, the ability of brain cells and networks to change some aspects of how they work, particularly how they connect with one another (Choquet & Triller, 2013). This ability serves as the basis for learning and memory throughout our lives (e.g., Kolb et al., 2017), but it can also play a role in recovery from brain damage (Luft et al., 2013). Recognizing this role, rehabilitation neuropsychologists work to take advantage of it. For example, they use functional MRI and other measures of brain activity to help occupational therapists, speech and language therapists, and physical therapists choose interventions that are most likely to promote and exploit neuroplasticity (Crosson et al., 2017).

Neuroplasticity

The ability of brain cells and networks to change some aspects of how they work

Neuropsychologists have also developed interventions that encourage neuroplasticity after brain damage (Taub, Uswatte, & Elbert 2002). One example is the use of transcranial magnetic stimulation (TMS), a technique in which a powerful magnet is placed over specific locations on a person's skull, thus affecting brain activity at these locations. There is evidence that the neural excitation created by TMS after brain damage is followed by measurable improvements in neuropsychological functioning (Miniussi & Rossini, 2011). There are also low-tech interventions intended to promote neuroplasticity, including special mental exercises designed by neuropsychologists that appear to improve memory in brain-damaged people with amnestic disorders (Simon et al., 2019).

In Review Neuropsychological Assessment

<table>
<tr><th>Testing Approach</th><th>Description</th></tr>
<tr><td>Test battery</td><td>A set of standardized tests intended to cover a broad range of the possible impairments that brain damage might cause. The best-known example is the Halstead–Reitan Battery, which contains 10 core tests.</td></tr>
<tr><td>Individualized</td><td>Allows clinicians to give a small group of initial tests followed by additional tests aimed at assessing questions related to a particular patient’s performance.</td></tr>
<tr><td colspan="2">Test Yourself

1. The Halstead–Reitan battery has been found ______ valid for diagnostic purposes than the Luria-Nebraska battery.

2. It is easier to test the validity of the __________ approach to neuropsychological testing than to test the validity of the _____________approach.

3. A neuropsychological deficit is best defined as a patient’s poor performance on a task when compared with appropriate ___________.

You can find the answers in the Answer Key at the end of the book.</td></tr>
</table>

Neuropsychological Approaches to Psychopathology

Section Preview Neuropsychologists study the brain functioning of people diagnosed with depression, schizophrenia, developmental disorders (sometimes called learning disabilities), and other psychological disorders.

In addition to advancing our understanding of the relationships between psychological and brain processes, research in neuropsychology has contributed to our understanding of psychological disorders, including depression and schizophrenia. Neuropsychological research has also expanded knowledge of several childhood problems, especially learning disorders.

Depression

Neuropsychologists have been interested in depression ever since Guido Gainotti (1972) documented in a systematic fashion that localized brain damage can produce emotional effects. It is now widely recognized that stroke-induced brain damage commonly produces depression (Mitchell et al., 2017). Interestingly, individuals with right-side brain damage may show a more cheerful, inappropriate, unconcerned reaction to their impairment and hospitalization than those with left-side damage. This “euphoric” or “indifferent” reaction is often accompanied by anosognosia (unawareness of deficit). Individuals with left-brain damage more often have a “catastrophic” reaction, displaying tearfulness, despair, and other symptoms of depression. In fact, one- to two-thirds of patients with left-side damage become depressed (Starkstein & Robinson, 1988), and the probability and severity of depression rises the closer the lesion is to the frontal pole of the left hemisphere (Ilut et al., 2017). Functional MRI studies show that a person is also more likely to suffer post-stroke depression if there has been degeneration in the limbic system, which includes brain areas that normally participate in processing various aspects of emotional life (Magnin et al., 2019).

To some degree, different emotional responses may stem from the direct effects of losing certain areas of brain function, not simply because people are upset about being impaired. One reason for thinking so is that the degree of depression does not correlate with the severity of disability per se (e.g., Folstein, Maiberger, & McHugh, 1977). Another reason stems from the fact that activity in different brain areas has different effects on emotion even in people without brain damage (e.g., Herrington et al., 2005). Some people

who are depressed, but have no apparent brain damage display deficits on neuropsychological assessment measures. Following successful treatment of the depression, these deficits are typically reduced.

The left hemisphere in people who are clinically depressed is typically less active than the right. Similarly, when people who are not clinically depressed happen to be feeling sad, the left hemisphere is less active than the right hemisphere. These differences in brain activity are most evident over the frontal regions of the brain, confirming their importance for these emotional effects. When depressed and non-depressed individuals read words that are rated as pleasant, they all show more brain activity in the left dorsolateral (top and outside part) frontal lobe than the right, but this difference is less strong in depressed patients (Herrington et al., 2010). Such findings suggest that decreases in left frontal brain function could be part of the brain changes that occur in a depressed state.

Tachistoscopic studies have also shown that when people see briefly flashed pictures, their left hemispheres typically rate the pictures as more positive than their right hemispheres do— even though each hemisphere has seen exactly the same images (Heller, 1990). These results suggest that in the healthy brain, regions of the left hemisphere play some role in maintaining a positive perspective on things. In other words, it may be that negative mood states can result after a lesion or other condition causes left-side brain areas to be underactive relative to those in the right hemisphere.

Other studies have found that depression is associated with decreases in right posterior activity (Heller & Nitschke, 1997). People who are depressed show some of the same cognitive deficits displayed by patients with damage to parietal-temporal regions of the brain. They have difficulty with visuospatial information processing and show a number of attentional

problems that are similar to patients with right-brain damage. These effects may be caused by the interrelationship between the brain's frontal and posterior regions. Because frontal regions often inhibit activation in posterior regions, greater activation in the right frontal region compared with the left may be producing too much inhibition of the right posterior regions.

These neuropsychological findings have implications not only for our understanding of depression but also for its diagnosis and treatment after brain damage (Bhattacharjee et al., 2018). For example, it is important to consider the possibility that in addition to having problems with impaired language comprehension or expression, a patient with brain injury may also be depressed. Accordingly, clinical neuropsychologists typically ask patients and their family if the patient is sleeping and eating normally and recovering as expected. If not, an underlying depression may be present and may require treatment with antidepressant medication and/or psychotherapy.

Schizophrenia

Neuropsychologists have long been involved in studying brain functioning in people with schizophrenia, but they have yet to find a consistent pattern of brain dysfunction. Early studies, most of which used tachistoscopic methods, suggested the possibility that schizophrenia is characterized by an overactivation of the brain's left hemisphere (Gur, 1978). However, further research into the differences between left and right-hemisphere function shows that the picture is more complicated than that (Ribolsi et al., 2009). It may be, for example, that certain characteristics of early brain development may interfere with the appearance of the usual degree of left versus right cerebral hemisphere specialization later in life (Núñez et al., 2017).

Both structural and functional abnormalities have been demonstrated in the prefrontal cortex of people with schizophrenia (Bähner & Meyer-Lindenberg, 2017; Panagiotaropoulou et al., 2019). Studies measuring regional cerebral blood flow and glucose metabolism suggest that the left prefrontal region of these people's brains is abnormal because this region is not activated during assessments such as the Wisconsin Card Sorting Test, which is widely regarded as a good measure of executive functioning. In contrast, subcortical regions of the same hemisphere show a hyperactivation compared with non-schizophrenic control participants (Rubin et al., 1991). Studies with functional MRI show that the left prefrontal cortex does not activate normally during a language task, and this brain region also appears to have weaker than normal connections with other brain regions (Bleich-Cohen et al., 2012). Some researchers believe that the results of these neuropsychological and brain imaging studies point to dysfunction of the

prefrontal regions, particularly of the left hemisphere, as a fundamental characteristic of brain dysfunction in schizophrenia (Kelley, 2011).

These results are compatible with several observations of the symptoms of schizophrenia. Many individuals with schizophrenia display *negative symptoms*, which involve reductions in normal functioning, including “flat” affect, lack of initiative, lack of energy, absence of social engagement, and loss of spontaneity. These same losses are encountered in certain patients with structural lesions to prefrontal regions. Schizophrenia patients can also show *positive symptoms*, in the form of problematic additions to mental life, including illogical reasoning, delusions, hallucinations, intrusions into working memory, neologisms (new words), rhyming speech, and other odd language utterances. It is interesting to note that these problems can also be seen after some kinds of damage to specialized regions of the left hemisphere.

Some research suggests that disruptions of right-hemisphere processing may be involved as well, because the right hemisphere has been associated with affective and social functions that are impaired in schizophrenia (Mitchell & Crow, 2005). Other research has raised the possibility that disconnections between frontal and temporal, and perhaps other, brain regions may also be related to the pathology seen in schizophrenia patients (Brambilla et al., 2005; Meyer-Lindenberg et al., 2001). Unfortunately, however, a complete and integrated neuropsychological account of schizophrenia is still lacking.

Developmental Disorders

Given neuropsychologists' interest in cognitive abilities, it is not surprising that many of them focus their research, assessment, and intervention efforts on learning disorders. Much of their work focuses on the role of behavioral, environmental, and social factors in these disorders, but they have discovered some fascinating biological correlates, too. Several neuropsychological studies have found, for example, that developmental dyslexia (disruptions in the ability to read) is usually related to dysfunction of the left hemisphere (Shaywitz & Shaywitz, 2005). Brain imaging studies show that variations in children's reading ability across both normal and dyslexic ranges correlate with microstructural variations in left-hemisphere nerve cell pathways (Niogi & McCandliss, 2006). Indeed, even before they learn to read, children who later develop dyslexia show abnormal activity in left-hemisphere language regions (Raschle, Zuk, & Gaab, 2012). In children who already display developmental dyslexia, those with greater right-hemisphere frontal lobe activation on functional MRI are the ones who seem to respond best to special training to improve their reading performance (Hoeft et al., 2011). Similarly, in a tachistoscopic word-reading task, children diagnosed with dyslexia did better than normally developing readers when words were presented to the right hemisphere (Saban-Bezalel, Coral, & Mashal, 2019).These results suggest that overcoming the effects of developmental dyslexia depends on being able to use nontraditional right-hemisphere brain regions for reading functions.

The results of postmortem examinations of people who had been diagnosed with dyslexia also show that the structure of their left hemispheres

differs from that of people without dyslexia. Researchers have found evidence for misplaced brain cells, called *ectopias*, in the left hemisphere. Instead of migrating to their proper places during the early stages of brain development, these cells appear to have “gotten lost,” and some researchers suggest that these “lost” ectopias can cause developmental delays and deficits in the functioning of the left hemisphere.

Assessments by pediatric clinical neuropsychologists can often help to delineate specific difficulties in children’s left-hemisphere functioning and help design remedial strategies. In fact, children who display school-related attentional difficulties (including ADHD), memory and language problems, and social and emotional problems (including depression and anxiety) are often referred to a pediatric clinical neuropsychologist. These clinicians typically conduct a thorough examination and then consult with teachers and parents on how best to help the child.

There is also a special type of learning disorder that involves deficits in visuospatial and visuomotor skills, as well as in other abilities that depend on the right hemisphere (Grodzinsky, Forbes, & Bernstein, 2010). This syndrome of *nonverbal learning disorder* (also known as *nonverbal disability*) was first described in the mid-1970s (Myklebust, 1975), but neuropsychological research has only recently been focused on delineating this disorder (Spreen, 2011). Children with nonverbal learning disorders may have long escaped the notice of professionals because they are often talkative and show high levels of verbal intelligence. Consequently, they sound as though they should be more skillful in the nonverbal realm than they actually are. In fact, these children often have difficulty keeping up with other children on nonverbal tasks. They are slow to learn such skills as tying shoes, dressing, eating, and organizing their time and their environment. Because

their difficulties are relatively subtle, they are likely to be labeled as having an emotional or behavioral problem, not a learning disorder. Unfortunately, if these children are treated as “bad,” “uncooperative,” or “a problem” long enough, they may end up behaving accordingly. Thus, early diagnosis and treatment of nonverbal learning disorders is vital.

Nonverbal learning disorders may result from right-hemisphere deficits early in childhood, which can interfere with normal development (Rourke, 1989). These difficulties inhibit a child from exploring the environment, learning the consequences of actions, and gaining essential experience in coordinated visuomotor skills. They can also interfere with the process of attachment between an infant and its caregivers, a process that depends on nonverbal skills. Because mother–infant interaction predicts the quality of attachment during the toddler phase, and because the quality of attachment predicts social adjustment in early and middle childhood, problems in right-brain functioning can not only create early motoric and cognitive difficulties, but also can lead to abnormalities in social relationships that place the children at risk for emotional difficulties later in life.

Some of the social development difficulties seen in these children are probably related to their inability to meet the intense demands for nonverbal information processing in social situations. Overwhelmed by the task of integrating information coming from other children’s facial expressions, tone of voice, physical activity, and verbal content, they fail to follow even simple exchanges. Over time, their lack of experience and interaction with other children can cause them to feel isolated, lonely, and depressed. It has even been suggested that nonverbal learning disorder may be a risk factor for the development of schizophrenia.

In assessing the possible presence of nonverbal learning disorders,

pediatric clinical neuropsychologists look first for a discrepancy between verbal and nonverbal tasks. If the same pattern appears on other tests comparing verbal and visual-spatial/visual-motor skills, a nonverbal learning disorder is likely to be diagnosed. Often, although not always, a pattern of poor performance on right-hemisphere tasks is accompanied by signs on the Halstead–Reitan Battery suggesting impaired right-hemisphere performance.

As they do in relation to other learning disorders, pediatric clinical neuropsychologists work to devise remedial programs for children with nonverbal learning disorders. They encourage parents and teachers to take advantage of the children’s verbal skills in ways that can help compensate for lack of understanding in nonverbal domains. They also recommend that these children receive individual attention from a learning disorders specialist or tutor. Without this help, their academic achievement is likely to fall behind that of their classmates as the demands of school increase. The children’s impaired social skills can often be addressed by group therapy, social skills workshops, individual therapy, facilitation of structured peer interactions, or participation in after-school programs.

In Review Neuropsychological Approaches to Psychopathology

Disorder	**Possible Neuropsychological Correlates**
Depression	Abnormal activity levels in the left frontal and right posterior brain regions.
Schizophrenia	Structural and functional abnormalities in the prefrontal cortex.
Developmental disorders	Abnormalities in left-hemisphere structure and functioning. Developmental dyslexia: greater use of right-hemisphere processing during reading. Nonverbal learning disorders: problems with right-hemisphere brain functioning.

Test Yourself

1. _________ is one of the most common psychological consequences of having a stroke, even if the stroke did not cause functional impairment.

2. Neuropsychological research suggests that dysfunctions in _____ brain regions, particularly in the ______hemisphere are associated with the appearance of schizophrenia.

3. Children with _________learning disorders tend to be talkative and have high verbal intelligence.

You can find the answers in the Answer Key at the end of the book.

The Current Status of Clinical Neuropsychology

The field of clinical neuropsychology has grown dramatically since the mid-20th century. In the late 1960s, the *International Neuropsychological Society* was founded; in the 1970s, clinical neuropsychology emerged as a distinct professional specialty; and in 1980, the *Division of Clinical Neuropsychology* (Division 40) was formed within the American Psychological Association and is now one of the APA's largest divisions. In 1996, the APA designated clinical neuropsychology as a psychological specialty, as it had previously done with clinical, counseling, and health psychology.

In 1997, neuropsychology specialists and educators met in Houston, Texas to develop guidelines for clinical neuropsychology training. The "Houston Conference" guidelines, revised in 2004 (Reitan et al., 2004), specify core knowledge bases and skills (see Table 13.3). Students acquire these skills and competencies in graduate school, internship, and postdoctoral residency. Those who have undergone the proper training and have had sufficient experience in the practice of clinical neuropsychology can apply to take the examination for diplomate status in clinical neuropsychology.

Table 13.3 Houston Conference Training Guidelines
The 1997 Houston Conference specified the core knowledge and skills necessary to become a clinical neuropsychologist.

Core Knowledge Area	Course Content
General psychology	Statistics and methodology, learning,

	cognition and perception, social psychology, biological bases of behavior, life-span development, history, cultural and individual differences
General clinical psychology	Psychopathology, psychometric theory, interviewing, assessment, intervention, and ethics
Foundations of brain–behavior relationships	Neuroanatomy, neurological and related disorders (and their causes, pathology, course and treatment), nonneurological conditions affecting central nervous system functioning, neuroimaging and other neurodiagnostics, neurochemistry of behavior, and neuropsychology of behavior
Foundations for the practice of clinical neuropsychology	Specialized assessment, intervention, research design and analysis, ethics and practical implications of neuropsychological conditions

Core Skills: Assessment, treatment and intervention, consultation, research, and teaching and supervision

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The establishment of the Houston Conference guidelines suggests that specialization within clinical neuropsychology will become increasingly common. For instance, a leading trend in neuropsychological research and practice has been an explosion in the use of functional magnetic resonance imaging (fMRI) and other high-tech brain-scanning techniques. Continued development and refinement of these techniques has made them more accessible to researchers and clinicians. The growth of interest in fMRI and other measures of brain function has also created a need for more highly

trained neuropsychologists (Matarazzo, 1992; Oakes & Lovejoy, 2013). After all, if researchers want to watch the activation of a brain region of interest during a particular kind of mental task, they need neuropsychologists who can develop and use tests that require that particular kind of information processing (Miller et al., 2007).

Neuropsychologists are also becoming more involved in designing effective interventions to help individual patients (Hunter & Donders, 2011; Ponds & Hendriks, 2006; Winocur et al., 2007). Many of these neuropsychologists work in rehabilitation settings where they design and implement appropriate services for patients and their families that take into account the cognitive, social, and emotional consequences of brain damage as well as the long-term needs of the people affected. In short, neuropsychologists will continue to provide patients with integrated and comprehensive diagnostic, assessment, and intervention plans.

Chapter Summary

The field of neuropsychology seeks to define the relationship between brain processes and human behavior and psychological functioning, including cognitive and motor abilities, emotional characteristics, personality traits, and mental disorders. Clinical neuropsychologists apply the results of neuropsychological research in their work with children and adults who have had brain trauma or injury or who are experiencing other problems related to brain impairment. Neuropsychology was not defined as a scientific field until the late 1940s, and clinical neuropsychology did not emerge as a distinctive professional specialty until the 1970s.

One of the most important organizational principles underlying brain–behavior relationships is localization of function, which refers to the fact that different parts of the brain are involved in different skills or senses. Lateralization of function is another vital feature of the brain's organization that has important implications for behavior. In most right-handed people, the left hemisphere is particularly specialized to handle speech and other linguistic processing, including the ability to understand and produce spoken language. The right hemisphere is particularly specialized for analyzing spatial and other nonverbal information, including complex signals involved in social communication.

Clinical neuropsychologists use a variety of tools and one of two main approaches to assess patients' cognitive, emotional, or behavioral deficits, and to relate these deficits to specific impairments in brain functioning. In the battery approach, a standardized set of tests is given to all patients, while in

the individualized approach, a set of tests is selected depending on the characteristics of each patient. The most widely used assessment battery is the Halstead–Reitan Neuropsychological Test Battery. It consists of ten core tests and is usually combined with the MMPI-2 and an IQ test. A prominent individualized approach has been developed by Muriel D. Lezak.

Today neuropsychology research is helping clinicians better understand a variety of psychological disorders, including depression, schizophrenia, and verbal and nonverbal learning disorders. APA’s Division of Clinical Neuropsychology has defined the training and educational experiences necessary to become a clinical neuropsychologist and established criteria for demonstrating competence in this specialty.

14

Forensic Psychology

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Contents

The Scope of Forensic Psychology
Criminal Competence and Responsibility
Assessing Psychological Status in Civil Cases
Psychological Autopsies and Criminal Profiling
Child Custody and Parental Fitness
Mental Health Experts in the Legal System

Chapter Preview

This chapter describes a number of ways that clinical psychologists contribute to the legal system and to legal decision-making. Forensic psychologists contribute to decisions about whether a defendant is competent to stand trial, whether a defendant was insane at the time he or she committed a crime, and whether certain individuals are a threat to themselves or others. Clinicians also become involved in civil actions, such as determinations about the role of stress or the extent of psychological damage following accidents or other events. Their involvement in criminal profiling and psychological autopsies is infrequent, but forensic clinical psychologists are commonly asked to perform activities such as psychological evaluations in child custody and divorce proceedings.

It was in the fourth edition of this book, published in 1994, that we first predicted that **forensic psychology**—a specialty that applies psychological principles and knowledge to legal issues and proceedings—would be a "growth stock" for clinical psychologists. Our prediction was accurate. It is now clear that the demand for psychologists to contribute in various ways to the legal system has grown to the point that forensic psychology has become a major professional activity and a focal point of scholarship among clinical psychologists. Numerous signs indicate this growth surge. For example, the number of doctoral degrees awarded in forensic psychology has increased by more than 400% between 2008 and 2017 (American Psychological Association, 2019a). The American Psychology-Law Society (Division 41 of the APA) now lists over 3000 members and publishes its own journal, *Law and Human*

Behavior; a newsletter, *American Psychology-Law News*; and a book series, *Perspectives in Law and Psychology*. In 1995, APA itself inaugurated the publication of *Psychology, Public Policy, and Law*, another major journal devoted to psychology and the law. There are also several other journals devoted to psychology and legal issues. The growing popularity of the field is evident, too, in the fact that there are now over 50 doctoral and master's degrees programs that focus on psychology and the law. There are even some undergraduate concentrations in forensic psychology. Perhaps the most significant indication of the expansion of the field was the American Psychological Association's approval, in 2001—and recertification in 2008—of forensic psychology as a specialty area of applied psychology, joining clinical, counseling, school, child, health, neuropsychology, and other practice areas.

Forensic psychology
A specialty that applies psychological principles and knowledge to legal issues and proceedings.

The Scope of Forensic Psychology

Section Preview Forensic psychologists apply psychological knowledge to a variety of legal contexts and legal decisions. They also conduct research on the effects of those decisions and on the effectiveness of interventions designed to help people avoid negative contacts with the law.

Forensic psychology (and forensic psychiatry, an allied branch in medicine) involves the application of mental health knowledge and expertise to the assessment and treatment of individuals who are in some way involved in the legal process or legal system (Otto, 2013). The term *forensic* comes from the Latin word *forensis*, meaning "of the forum," where the law courts of ancient Rome were held.

Clinical psychologists working in the forensic area may be involved in addressing a wide range of legal issues, including whether an individual is sufficiently mentally ill and potentially dangerous to justify involuntary hospitalization; a person charged with a crime is mentally competent to stand trial; the perpetrator of an illegal act was sane at the time of the offense; and a person suffered psychological harm as the result of an injury or trauma, and if so, how serious it is. Forensic psychologists might also be involved in competency questions relating to parental fitness, child custody, guardianship, and the execution of wills. They perform these tasks using specialized interviews and tests, as well as by conducting observational research. They are commonly asked to serve as expert witnesses in civil and criminal trials or other legal proceedings.

Clinical psychologists are active in other law-related areas, too. In *law enforcement psychology*, clinicians conduct research on the activities of the police and other law enforcement agencies and provide direct clinical services in support of these agencies (Shipley & Arrigo, 2012). A clinician working in this area might test candidates for police work to screen out those who are not psychologically fit (e.g., Detrick & Chibnall, 2013), offer crisis intervention to police officers involved in violent encounters, consult with detectives about what kind of individual might have committed a certain type of crime, help question witnesses in ways that enhance their recollections of crimes (e.g., Cassel, 2000; National Institute of Justice, 1999), and assist law enforcement personnel in administering lineups that minimize the chances of false identifications (Carlson, Grondlund, & Clark 2008; National Institute of Justice, 2007).

The *psychology of litigation* is concerned with the effects of various legal procedures used in civil or criminal trials. Clinicians working in this area may offer advice to attorneys about jury selection, study the factors (such as flaws in eyewitness memory) that influence jury deliberations and verdicts (Albright, 2017; Loftus, 2003; Loftus, Doyle, & Dysart, 2013), and analyze the effects of specific portions of trials, such as opening statements, examination and cross-examination of witnesses, and closing arguments (Marcus, Lyons, & Guyton, 2000).

Clinical psychologists also work in *correctional psychology*, primarily by delivering psychological services to incarcerated criminals (Schwartz, 2003; Van Voorhis & Salisbury, 2013). Most of these correctional psychologists work in prisons, penitentiaries, or juvenile facilities, but they may also operate out of a probation office or be part of special community-based correctional programs.

As research at the interface of psychology and law expands, so too does the scope of clinical psychologists’ activities in the legal arena. You can review these advancements in the journals we mentioned earlier, as well as in a variety of books on law and psychology. In the following sections, we will focus on the work of forensic psychologists in the areas of criminal responsibility, assessing psychological status in civil trials, psychological autopsies and criminal profiling, child custody and parental fitness, and expert testimony.

In Review The Scope of Forensic Psychology

Typical legal matters addressed by forensic psychologists	Assessment of dangerousness. Mental competence to stand trial or execute a will. Criminal responsibility. Degree of psychological damage suffered. Fitness to retain child custody. Likely characteristics of serial criminals.
Other areas of activity for clinical psychologists in the legal arena	Law enforcement psychology. Psychology of litigation. Correctional psychology.

Test Yourself

1. Assessment of a defendant’s mental competency to stand trial would likely be determined by a forensic psychologist using ________ and _______.

2. A clinician who offers therapy services to police officers traumatized by violent events works in the area of __________ psychology.

3. If you were a correctional psychologist, you would probably be working in a ________.

You can find the answers in the Answer Key at the end of the book.

Criminal Competence and Responsibility

Section Preview The law requires that criminal defendants be competent to assist in their own defense. It also requires that, to be held responsible for a crime, defendants must have understood that their behavior was wrong. Because these are psychological judgments, forensic psychologists are typically involved in decisions about criminal responsibility.

Courts allow defendants' mental conditions to be considered at trial because our society believes that it is immoral to punish people who, as a result of a mental disorder, either did not know that their actions were wrong or could not control their behavior. However, before a verdict is ever reached, courts must determine whether defendants are mentally competent to assist in their defense in court.

Criminal Competence

In January 2011, Jared Lee Loughner, a 22-year-old community college student, walked into a crowd that had gathered on the sidewalk at a Tucson, Arizona, strip mall to meet their federal congressional representative, Gabrielle Giffords. Loughner then shot 19 people, killing six and critically injuring Rep. Giffords and others. The dead included a 9-year-old girl and a federal judge. Loughner was charged with 49 offenses, including murder and attempted assassination of a federal official. His attorney claimed he was not mentally competent to stand trial. This argument was supported by testimony from psychologists who had examined Loughner, as well as from Loughner's acquaintances and fellow students, who recalled his increasingly odd behavior and paranoid rants about the government. This pretrial testimony convinced a judge that Loughner was suffering from a mental illness (schizophrenia), so instead of scheduling a trial, he sent Loughner to a state hospital for treatment.

In the United States, it is not permissible to continue criminal proceedings against a defendant who is unable to understand the nature and purpose of those proceedings. To assist the courts in determining a defendant's level of understanding, forensic psychologists assess the defendant's **competence to stand trial**. The legal standard for this kind of competence has not changed since the U.S. Supreme Court enunciated it in 1960: "The test will be whether [the defendant] has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding, and whether he has a rational as well as a factual understanding of the proceedings against him" (*Dusky v. United States*, 362 U.S. 402). In short,

defendants must be able to understand the proceedings that are taking place and be able to assist their attorneys to prepare their defense.

Competence to stand trial
A requirement that defendants must be able to understand legal proceedings against them and to help attorneys to prepare their defense.

Competence focuses on the defendant's "present ability" to proceed to adjudication and should be distinguished from retrospective inquiries regarding criminal responsibility (such as the insanity defense), which focus on the defendant's mental state at the time of the offense. A defendant is considered competent unless and until the defendant convinces the judge otherwise. Defendants must be competent not only at the time of the trial but also at the time of sentencing and, if they received a death sentence, at the time of execution.

Clinical psychologists are also often asked to evaluate other kinds of competence in criminal defendants, including competence to confess to a crime, competence to waive the right to an attorney, and competence to choose not to invoke the insanity defense.

The question of a defendant's competence can be raised by the prosecutor, the defense attorney, or the presiding judge at any point in the criminal process. It is estimated that competency evaluations are performed on 10 to 15% of criminal defendants in the United States each year (Hoge,

2016). With the increasing numbers of juveniles now being tried as adults for violent crimes, forensic psychologists are also turning their attention to how cognitive immaturity affects the legal competence of juveniles (Cassel & Bernstein, 2007; Grisso et al., 2003; National Juvenile Justice Network, 2012).

Assessing Competence

When a question of competence is raised, the judge will order a psychological evaluation. Most assessments take place at local community mental health centers, but if the defendant is suffering from a severe disorder such as major depression or schizophrenia, the evaluation may be performed at a mental hospital or some other inpatient facility. In most states, psychiatrists, psychologists, and social workers are authorized to perform competency evaluations, and they often use special structured interviews to do so (see Table 14.1).

Table 14.1 Assessing Competence to Stand Trial

The assessment of a defendant's competence to participate in criminal proceedings usually begins with a mental status examination, a brief focused interview designed to evaluate the defendant's memory, mood, orientation, thinking, and ability to concentrate (see Chapter 5). The clinician usually then administers one or more specialized instruments, such as the Competency Screening Test (CST), the Competency Assessment Instrument (CAI), or the MacArthur Competence Assessment Tool– Criminal Adjudication (MacCAT-CA) (Hoge et al., 1997).

Competency assessment instruments are designed to determine the defendant's ability to:

1. Understand the charges filed;

2. Understand the nature and range of possible criminal penalties if convicted;

3. Understand the adversarial nature of the legal process (prosecution versus defense);

4. Disclose to a defense attorney pertinent facts surrounding the alleged offense;

5. Relate to and communicate with the defense attorney;

6. Assist the defense attorney in planning a defense;

7. Realistically challenge the testimony of prosecution witnesses;

8. Behave appropriately in the courtroom;

9. Give relevant testimony in court; and

10. Engage in self-beneficial, as opposed to self-defeating, behaviors throughout the process.

Source: Heilbrun, K., & Collins, S. (1995). Evaluations of trial competency and mental state at time of offense: Report characteristics. *Professional Psychology: Research and Practice, 26*(1), 61–67. https://doi.org/10.1037/0735-7028.26.1.61

Although the burden of proving incompetence is only by a “preponderance of the evidence” (which is sometimes quantified as at least 51%), 70 to 80% of defendants referred for such evaluations are found competent (Pirelli, Gottdiener, & Zapf, 2011). The more rigorous the evaluation, the more likely it is that the defendant will be found competent (Heilbrun & Collins, 1995), but most states have a very low threshold for competence. Here is an example (Wrightsman, Nietzel, Fortune, & Greene, 2002):

Jamie Sullivan was a 24-four-year-old clerk charged with arson, burglary, and murder in connection with a fire he set at a small grocery store in Kentucky. Evidence in the case showed that, after closing time, Sullivan returned to the store where he worked and forced the night manager, Ricky Ford, to open the safe and hand over $800. Sullivan then locked Ford in a small office, doused the store with gasoline, and set it on fire. Ford died in the blaze. Police arrested Sullivan within hours at his grandmother's apartment on the basis of a lead from a motorist who saw him running from the scene.

If convicted on all charges, Jamie Sullivan could have faced the death penalty, but he was intellectually disabled. He had dropped out of school in the eighth grade, and a psychologist's evaluation at that time reported his IQ to be 68. He could read and write only his name and a few simple phrases. He had a history of drug abuse, and at age 15 had spent several months in a juvenile correctional camp, after vandalizing five homes in his neighborhood. When he tried to enlist in the army, he was turned down because of his limited intelligence and drug habit. Jamie's attorney believed that Sullivan's mental problems might render him incompetent to stand trial and therefore asked a psychologist to conduct an evaluation. The psychologist asked Jamie a series of questions about his upcoming trial, to which he gave the following answers:

Question: What are you charged with?

Answer: Burning down that store and stealing from Ricky.

Q: Anything else?

A: They say I killed Ricky too.

Q: What could happen to you if a jury found you guilty?

A: Electric chair, but God will watch over me.

Q: What does the judge do at a trial?

A: He tells everybody what to do.

Q: If somebody told a lie about you in court, what would you do?

A: Get mad at him.

Q: Anything else?

A: Tell my lawyer the truth.

Q: What does your lawyer do if you have a trial?

A: Show the jury I'm innocent.

Q: How could he do that best?

A: Ask questions and have me tell them I wouldn't hurt Ricky. I liked Ricky.

Q: What does the prosecutor do in your trial?

A: Try to get me found guilty.

Q: Who decides if you are guilty or not?

A: That jury.

After interviewing and testing Sullivan, the psychologist found that his IQ was 65, which qualifies for a diagnosis of intellectual disability if

accompanied by failure to display age-appropriate life skills. Jamie expressed strong religious beliefs that "God watches over his children and won't let nothing happen to them," but the clinician found no evidence of the hallucinations or delusions that are frequently associated with a psychotic disorder. At a hearing to determine Jamie's competence to stand trial, the psychologist testified that due to the defendant's low IQ, his understanding of the court proceedings was not as accurate or thorough as it might otherwise be. However, the psychologist also testified that Sullivan did understand the charges against him as well as the general purpose and nature of his trial. The judge ruled that Jamie Sullivan was competent to stand trial and a jury convicted him on all the charges and sentenced him to life in prison.

What sort of person is typically judged to be incompetent to stand trial? One review of 50 years of research found that the defendants most likely to be found incompetent are unemployed, diagnosed with a psychotic disorder, and/or have a history of psychiatric hospitalization (Pirelli, Gottdiener, & Zapf, 2011). Another large-scale study also concluded that most people found incompetent are suffering from a severe mental disorder, such as schizophrenia (Poythress et al., 2002), but this does not mean that everyone with a schizophrenia diagnosis is found to be incompetent. Rather, it is people with a long history of schizophrenia or whose disorder has gone untreated who are more likely to be unable to assist in their defense.

If a competency evaluation finds a defendant competent, the legal process resumes and the defendant faces trial. If the defendant is found incompetent, the picture becomes more complicated. For crimes that are not serious, the charges might be dropped, sometimes in exchange for requiring the defendant to receive treatment, usually some kind of psychotropic medication. If the charges are serious, the defendant usually is returned to an

institution for treatment designed to restore competence, which, if successful, will result in the defendant ultimately standing trial. In most states, this mandatory treatment can last up to 6 months (4 months if the defendant is being tried under federal law), after which, if the person is still judged incompetent, the prosecutor may seek long-term "civil commitment" to an inpatient facility by showing that the defendant is a danger to self or others (Heilbrun et al., 2019). In the case of a minor, nonviolent offense, the defendant might simply be released. Most incompetent defendants are restored to competency through psychotropic medications, at which time they are returned to jail to await trial.

Can a mentally ill defendant be forced to take medication solely for the purpose of being made competent to stand trial? In the case of *Sell vs. United States* (2003), the Supreme Court said that under certain conditions, the answer is yes. Charles Sell was a former dentist who had been hospitalized several times because of various psychotic episodes. At one point, for example, he believed that the gold fillings in his teeth had been contaminated by communists and told law enforcement officers that a leopard was outside his office trying to board a bus. He was later charged with insurance fraud associated with his dental practice, which led to further charges of trying to intimidate a witness and threatening to kill an FBI agent involved in the fraud case. Sell was sent to a federal facility to determine his competence, found incompetent, and ordered to take antipsychotic medication to allow him to stand trial. He appealed the medication order and when his case reached the Supreme Court, the justices ruled that a criminal defendant could be involuntarily medicated to be able to stand trial if the treatment is medically appropriate, is substantially unlikely to have side effects that could undermine the fairness of the trial, and, taking account of less intrusive

alternatives, is necessary to significantly further important governmental trial-related interests. The Supreme Court remanded the case to the trial court to conduct a hearing based on its requirements. The result of the Sell decision to date has been that, in a large number of court cases, including more than 63% of federal cases, prosecutors pursue rather than drop cases against defendants whose competence can be established through medication (McMahon, 2013). This situation raises a host of ethical issues, especially for physicians who find themselves in the position of restoring mental competence to defendants who then may well receive long prison sentences or even the death penalty.

The Insanity Defense

If Charles Sell had gone to trial (he eventually plead no contest) he would almost surely have plead **not guilty by reason of insanity (NGRI)**. No area of law illustrates the controversies surrounding expert testimony as dramatically as the question of whether a defendant was insane while committing a crime. Proving insanity can result in a defendant's being acquitted, in which case the finding is NGRI. As we describe later, some U.S. states also allow for a verdict of **guilty but mentally ill (GBMI)**, meaning that the defendant will be sentenced to prison, but ordered to receive such mental health treatment as the correctional institution deems appropriate.

Not guilty by reason of insanity (NGRI)
A verdict that, at the time of a crime, a defendant was suffering a mental disorder and either did not realize the wrongfulness of the act or was unable to conform to the law.

Guilty but mentally ill (GBMI)
A verdict in which a mentally disordered criminal is to be treated for the disorder while serving a prison sentence for the crime.

To understand the legal concept of insanity, you must recognize certain facts about criminal law and how crimes are punished. A crime is an intentional act (or failure to act) that is a violation of criminal law and committed without a defense or excuse. But even acts that are prohibited by law generally will not rise to the level of criminal conduct unless the accused person possesses *mens rea*, or a “guilty mind” whose intent is to do wrong. This is the mental element of culpability. Criminal defendants are presumed to possess *mens rea* and to be legally responsible for the crimes with which they are charged. Therefore, if defendants plead NGRI, they must present evidence that they lacked the state of mind necessary to be held responsible for a crime.

Many people assume that being found “insane” is the same as being diagnosed as “psychotic,” but this is not the case. Because insanity is a legal term, not a psychological or psychiatric concept, it is defined by legal standards that have evolved over time. These standards began to be formalized in 1843, when an Englishman named Daniel M’Naughton tried to assassinate the British prime minister, Robert Peel. M’Naughton suffered from paranoid delusions that Peel was conspiring against him, so he waited outside the prime minister’s house at Number 10 Downing Street, where he shot and killed Peel’s secretary, whom he mistook for the prime minister. M’Naughton was charged with murder but pleaded not guilty by reason of insanity, claiming that he did not know the difference between right and wrong. Nine medical experts testified that M’Naughton was insane and, after hearing instructions from the judge, the jury did not even bother to leave the courtroom before deciding that M’Naughton was not guilty by reason of insanity. This verdict infuriated the British public, and Queen Victoria was particularly upset because she herself had been the target of several

assassination attempts. She demanded that Britain toughen its definition of insanity.

After extended debate in Parliament and among the nation's highest judges, a definition of insanity known as the *M'Naughton rule* was enacted: "… to establish a defense on the grounds of insanity, it must be clearly proved that, at the time of committing the act, the accused was laboring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing or, if he did know it, that he did not know what he was doing (was) wrong" (quoted in Post, 1963, p. 113).

In the United States today, the criteria for insanity differ by states, making matters rather confusing. As of 2020, four states—Idaho, Kansas, Montana, and Utah—had no insanity defense, and the other 46 had various versions of it. The federal system has its own rule as well, but most insanity laws place the burden on defendants to prove by "clear and convincing evidence" that, at the time of their crimes, they were suffering from a serious mental disease or defect and either lacked "substantial capacity" to appreciate the criminality or wrongfulness of their conduct or were unable to conform their behavior to the requirements of law. As you might imagine, determining whether a defendant lacked "substantial capacity" is very much a subjective judgment. In the minority of states where the prosecution must prove the defendant to be sane, the burden of proof is "beyond a reasonable doubt."

These criteria played an important role in the life of Rachel Jackson's maternal grandfather, Adomas Bagdonas. As a young man in Lithuania, he had been a problem drinker and showed signs of paranoia. A clinical psychologist might have diagnosed him with a delusional disorder, a substance use disorder, and perhaps schizotypal personality disorder. In any case, when, at the age of 27, Adomas came to the United States with his wife

Danutė, he was already displaying significant psychological and behavioral problems. Within 4 years, the couple had two children, Regina, and Rachel's mother, Lena, but when Lena was 14, Adomas abandoned his family and moved to another city. Not long afterward, while drinking heavily at one of his favorite bars, he began talking with a man known to him as Jovic, another regular customer, who usually kept to himself. Something Jovic said led Adomas to decide that Jovic was a Lithuanian government agent sent to spy on him. He accused Jovic of reading his thoughts and transmitting them wirelessly to a central intelligence agency in Lithuania. Jovic laughed and mocked Adomas, saying, "Why would anyone care what you think, you stupid drunk?" This insult infuriated Adomas, who got off his bar stool and hit Jovic so hard that he fell backwards, hitting his head on the concrete floor and losing consciousness. An ambulance and the police were called, and Jovic was transported to a hospital. He had suffered a fractured skull and a brain hemorrhage, and despite the emergency room physicians' best efforts, Jovic died the next day.

Adomas was charged with felony assault, but his paranoid delusions led the public defender to ask for a competency hearing. Adomas was found not competent to stand trial and was sent to a state psychiatric hospital, where, after being evaluated by a forensic clinical psychologist, he agreed to take psychotropic medication. While there, the charge against him was changed to voluntary manslaughter, an unlawful "heat of passion" killing in which the defendant has killed someone, but is not thought to have had the malice or *mens rea* required to justify a murder charge. This new charge led the judge to order another competency examination, and this time—probably because of the medication he agreed to take—Adomas was found competent to stand trial. He entered a plea of not guilty by reason of insanity. At his trial a

forensic psychologist testified that, at the time of the fight, Adomas met the criteria for insanity, because he was suffering from a mental disorder and was unable to appreciate the wrongfulness of his actions. The jury found Adomas not guilty by reason of insanity, but because he was still considered to be mentally ill and a public danger, he was sent to a psychiatric hospital, where he died of cardiac arrest at the age of 45.

Assessing Sanity

It is a relatively straightforward matter to assess a defendant's competence because it requires only a determination of the defendant's present mental status. Assessing a defendant's mental condition during a criminal act that took place weeks, months, or even years earlier is a much tougher challenge. To help them accomplish this task, forensic clinical psychologists and other mental health professionals use a variety of methods, such as reviewing the defendant's family, educational, employment, and medical history; ascertaining if the defendant has a history of prior criminality or mental disorder and treatment; listening to the defendant's version of the crime; and administering a variety of psychological assessments.

These assessments typically include a structured interview as well as intelligence tests (e.g., either the Wechsler Adult Intelligence Scale or the Stanford–Binet Intelligence Scale), objective personality assessments such as the Minnesota Multiphasic Personality Inventory (MMPI-2) and the Psychopathy Checklist–Revised (PCL-R). They might even include projective instruments such as the Rorschach Inkblot Test, and the Thematic Apperception Test (TAT), but because of concerns about their reliability and validity (see Chapter 5), some critics have questioned whether these tests meet scientific standards for forensic purposes (Grove et al.,, 2002). Defendants whose history, observed behavior, or intelligence test results suggest the possibility of brain dysfunction may also be given neuropsychological tests, such as those from the Halstead–Reitan battery. If there is a history of head trauma, brain injury, or recent change in personality or behavior, brain imaging procedures (such as an fMRI and CT scan) may

help determine if brain function or structure are compromised by disease or injury. (See Chapters 4, 5, and 13 for details about these assessment methods.)

Although an estimated 20 to 25% of defendants attempt to malinger, or "fake," mental illness, assessment instruments and astute clinicians can be successful in detecting such deception (Rogers, 2012; see Chapter 5). A famously identified malingerer was Kenneth Bianchi, one of two serial killers who came to be known as "Hillside Stranglers." Bianchi murdered more than a dozen young women in California and Washington in the 1970s. Although four experts had diagnosed him as having multiple personality disorder (now known as dissociative identity disorder), a savvy prosecution expert, psychiatrist Martin Orne, determined that Bianchi was faking this condition. With his cover blown, Bianchi abandoned his insanity plea and pled guilty to murder in exchange for the opportunity to escape the death penalty (Cassel & Bernstein, 2007). The Bianchi case provides an example of why—as described below—so few criminal defendants attempt to use the insanity defense.

The Role of Expert Witnesses in the Insanity Defense. In federal courts and most states, forensic clinical psychologists and other expert witnesses are not allowed to give an opinion regarding the so-called "ultimate issue" that is, whether a defendant was "sane" or "insane" at the time of committing an offense. Federal Rule of Evidence 704 puts it this way: "No expert witness testifying with respect to the mental state or condition of a defendant in a criminal case may state an opinion or inference as to whether the defendant did or did not have the mental state or condition constituting an element of the crime charged or a defense thereto. Such ultimate issues are matters for the trier of fact alone" (U.S. Department of Justice, 2019). In

other words, sanity is a legal question that only the judge or jury can answer; indeed, “insanity” is not a label in the official diagnostic manual of the American Psychiatric Association (*DSM-5*). Expert witnesses can only testify to a defendant’s symptoms, behaviors, and diagnosis.

According to a 1985 U.S. Supreme Court decision in the case of *Ake v. Oklahoma*, indigent (poor) defendants have the right to have experts assist in their insanity defense, but not to the expert of their choice. Unless there are special circumstances or an unusual mental disease or defect, indigent defendants are evaluated by state or federal government-employed mental health professionals, most of whom are qualified and competent witnesses. Of course, a person who can afford more than one expert, or the most expensive expert, might mount a more impressive insanity defense than a less affluent defendant, but this economic reality applies to any kind of legal defense. Having more experts does not necessarily guarantee an insanity verdict, however; even uncontradicted mental health testimony does not always influence juries. Often jurors perceive psychology and psychiatry to be “soft sciences” that are too dependent on subjective interpretations to be used as the basis for decisions about a defendant’s guilt or innocence (e.g., Faust, 2011; Rohde, 1999).

This view may change as testimony by forensic neuroscientists makes its way into the courtroom. These scientists are increasingly recognized as experts who not only can explain how brain structure and functioning underlies human behavior, but also can depict, with real-time, full-color imaging techniques, just what areas of the brain are responsible (Farahany, 2016; Rosen, 2007; Simpson, 2013; see Chapter 13 for more on the strengths and limitations of contemporary brain-scanning technology). Of course, jurors still must determine if brain malfunction releases someone from

criminal liability, so the essence of the insanity issue has not changed (Slobogin, 2017).

Thinking Scientifically Does the Insanity Defense Allow Killers to Get Away with Murder?

In 1982, when John Hinckley avoided going to prison by using the insanity defense at his trial for the attempted assassination of President Ronald Reagan the previous year, federal law did not require his lawyers to prove that he was insane. Instead, it required the prosecution to prove that he was sane, a difficult task since Hinckley had a clear history of disordered behavior consistent with a diagnosis of schizophrenia (Bonnie, Jeffries, & Low, 2000). After Hinckley was found NGRI, public pressure led to a revision of federal law to require defendants to prove insanity, and as already noted, this is now the rule in most states.

What am I being asked to believe or accept?

The uproar over the Hinckley verdict illustrated widespread dissatisfaction with the insanity defense, a dissatisfaction based partly on the claim that it is easy for criminals to use a plea of insanity to evade punishment, that their pleas are usually successful, and that after being found NGRI, they can walk free from the courtroom (see Meynen, 2016).

What kind of evidence is available to support the claim?

The main evidence for this claim comes from cases like Hinckley's. There was no doubt that he tried to kill President Reagan, but because

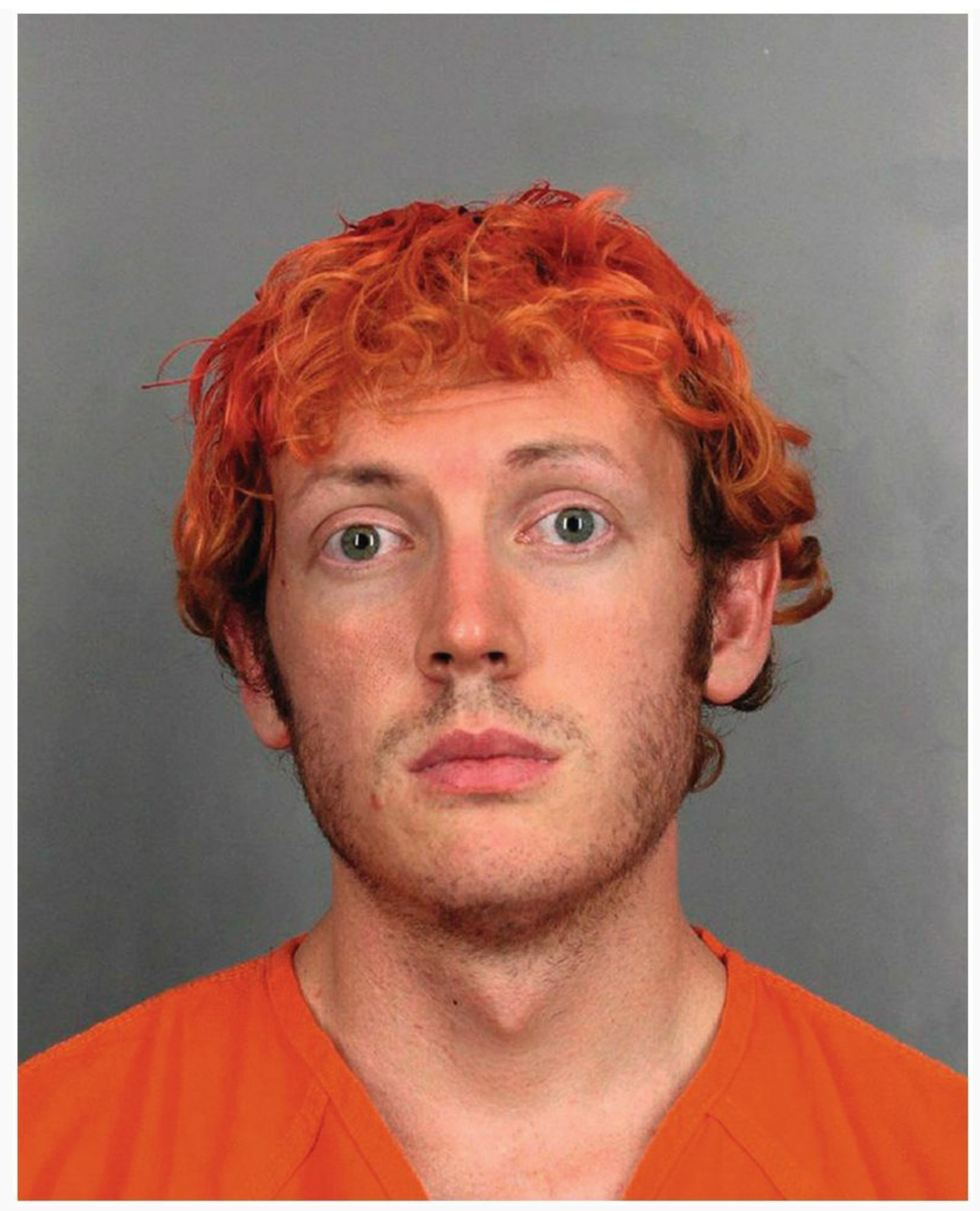
he was found NGRI, he served no jail time. He was sent instead for treatment at St. Elizabeths Hospital in Washington, DC. While there, he was repeatedly evaluated by forensic psychologists and psychiatrists and as he improved, he was allowed longer and longer visits with his parents at their nearby home. In 2016, after being declared free of mental illness and no longer dangerous, Hinckley was released into the custody of his mother (his father had died). True, he was confined for a long time and he now lives under a variety of restrictions (e.g., no alcohol or firearms, and he must stay within 50 miles of home), but many people are upset that someone who tried to assassinate a sitting U.S. president is now living a reasonably normal life.

There is concern, too, that even when the insanity defense fails, it might later succeed. That is what happened in the case of Andrea Yates, a Texas mother who drowned her five children in the bathtub of her Houston, Texas, home in 2001. Her long history of serious mental illness, including schizophrenia and major depression, made her a perfect candidate for the insanity plea, but it did not work. She was sentenced to serve life in prison, but she appealed her conviction, was granted a new trial, and in 2006 was found NGRI. She is now being treated in a psychiatric hospital.

Are there alternative ways to interpret the evidence, including those that my biases and preconceptions might have kept me from seeing?

As distressing as such outcomes may be for the public, and certainly for the families of crime victims in NGRI cases, considering all the

evidence about the insanity defense provides a broader perspective. Although surveys indicate that many members of the general public believe that insanity pleas are common (Lilienfeld et al., 2010), the fact is that they are quite rare and seldom succeed. They occur in only 1 out of every 100 criminal cases and are successful in only about 25% of the cases in which they are raised (Borum & Furelo, 1999; Cassel & Bernstein, 2007; Schmalleger, 2012). So, for each successful insanity plea, many more are unsuccessful, including those of such high-profile criminals as Jack Ruby, killer of John Kennedy's assassin Lee Harvey Oswald; Sirhan Sirhan, assassin of Robert Kennedy; and serial killers John Wayne Gacy, Jeffrey Dahmer, David Berkowitz (the "Son of Sam"), Kenneth Bianchi, and Ted Bundy. Even people diagnosed with schizophrenia or other delusional disorders may not be able to convince a jury that they were legally insane at the time of their crime.



In 2012, James Holmes killed 12 people and injured 70 others at a movie theater in Aurora, Colorado. At his trial, he pleaded NGRI, but like many other high- and low-profile defendants who use the insanity defense, he was convicted and is now serving life in prison without the possibility of parole.

As to the widespread claim that successful insanity pleas routinely allow NGRI defendants to go free, the evidence is quite the opposite. The vast majority of these defendants, like John Hinckley, Adomas Bagdonas, and Andrea Yates, are immediately confined to a treatment facility; recent estimates suggest that there are about 35,000 of them (Montross, 2016). Rarely would an NGRI acquittee be released without any restrictions. The length of time that the estimated 35,000 NGRI acquittees are confined varies with the severity of the crime and the seriousness of the mental illness, but it is usually for several years (Miraglia & Hall, 2011; Roesch, Zapf, & Hart, 2010) and, for many, for life (McClelland, 2017).

States are required to review the acquittees' mental status periodically, and in accordance with the U.S. Supreme Court judgment in the case of *Foucha v. Louisiana* (1992), defendants such as Hinckley, who are judged no longer mentally ill and not dangerous cannot be confined further. However, many severely mentally ill NGRI defendants may never be released and thus are confined longer than they would have been had they merely been convicted. Daniel M'Naughton himself, whose case gave us the insanity defense, died after 20 years in a psychiatric hospital.

What additional evidence would help to evaluate the alternatives?

In thinking about the value and fairness of the insanity defense, it is worth considering the characteristics of the typical defendants who are found NGRI. They are broadly similar to the typical defendants found incompetent to stand trial. This finding is not surprising, as the most successful insanity pleas involve defendants who at one point

were deemed incompetent (Schmalleger, 2012). NGRI acquittees are generally seriously mentally ill, unemployed white males in their 20s and 30s who have a history of hospitalization for mental illness and/or a history of arrest. Few have high school educations. Most have been charged with nonviolent crimes.

If confinement for treatment following NGRI verdicts were found to restore most of these people to a condition that allows them to function adaptively outside hospital walls without endangering others, it would suggest that the insanity plea has value for society. That outcome is far from certain, however. About 40% of NGRI defendants are re-arrested for crimes, some of them serious crimes, within 5 years of their release from the hospital (Torrey et al., 2017), and as we discuss in Chapter 3, mental health professionals are still not able to predict with certainty which individuals will be in that 40%. It is no wonder, then, that many members of the public argue that the plea should be abolished so that obviously guilty people serve prison time, not hospital time, for their crimes. Some mental health professionals and legal scholars, too, support abolishment of the insanity defense, but mainly because they favor other kinds of reforms, including those described in the next section.

What conclusions are most reasonable given the kind of evidence available?

Our society is constantly seeking the proper balance between protecting the rights of defendants and protecting society from dangerous criminals. The insanity plea is one element in that complex balancing act, but because it is used so infrequently, it plays a much

smaller role in the legal system than most people realize. It does, however, highlight the fact that, despite the progress being made in research on psychopathology and its treatment (Teachman et al., 2019), mental illness is still placing an enormous personal, social, and economic burden on our society (e.g., Kazdin & Blase, 2011). Our failure so far to find solutions that are adequate to successfully treat, let alone prevent, serious mental disorders will inevitably lead to criminal trials in which defendants’ mental status is an issue.

Reforming the Insanity Defense

For many decades, juries deliberating cases involving the insanity defense could only reach verdicts of guilty, not guilty, or not guilty by reason of insanity. Since 1976, however, 20 states have passed laws allowing juries to find defendants guilty but mentally ill (GBMI). This verdict option is available only for defendants who plead NGRI, but even states that have abolished the insanity plea itself still allow a (GBMI) verdict.

As mentioned earlier, a defendant found GBMI is usually sentenced to the same period of confinement as any other defendant convicted of the same crime. The intent of GBMI laws is to offer a compromise verdict that will decrease even further the number of defendants found NGRI. It seems to be working. Research on verdicts indicates that when states allow both GBMI and NGRI, jurors usually require stronger proof of insanity before returning a NGRI verdict (Roberts, Sargent, & Chan, 1993) and render GBMI verdicts when they believe defendants may not have been sane enough to be held legally responsible for their actions, but were culpable enough to warrant punishment (Sales & Shuman, 1996). Even in mock trials, where the role of juror is played by college students or other kinds of research participants, when given the choice between NGRI and GBMI, most "jurors" choose GBMI (Sloat & Frierson, 2005).

The court order in GBMI sentencing provides that the mentally ill defendant be given mental health treatment in the correctional facility. However, such treatment is rarely adequate, because GBMI convicts have no guarantee of medical care beyond the minimal level required by law for other convicts (Shipley & Arrigo, 2012; Slobogin, 1985; Steadman, 1993). Today,

there are about 350,000 mentally ill inmates in U.S. jails and prisons (Montross, 2016), or about ten times as many as those being treated in mental hospitals. This means that the task of confining seriously mentally ill people, a task once assigned to the large state mental hospitals that closed in the 1960s and 1970s, is now being performed by a correctional system that was not designed to do so. And as was the case in the hospitals they have replaced, the standard treatments available in most prisons are often not helpful, so these inmates' potentially dangerous disorders are unlikely to have been resolved by the time they are released (e.g., Morgan et al., 2013).

Some states have reformed their laws to allow a defense in which defendants may introduce evidence to show that at the time of their crime they had a "diminished capacity" to know right from wrong or to control their behavior (*Metrish v. Lancaster*, 2013). This defense is not designed to absolve the defendant of responsibility but to justify conviction on a lesser charge because of the defendant's reduced ability to form meaningful premeditation. A famous case occurred in 1978 when Dan White, a former member of the San Francisco Board of Supervisors, shot and killed both the city's mayor and a member of the Board. He was found to have had a "diminished" capacity for murder based on the now famous "Twinkie defense." White claimed that his reasoning was clouded by eating too much junk food. Though on trial for murder, the jury found him guilty of the lesser charge of manslaughter, and he was sentenced to 7 years in prison. Partly as a result of public outrage over this verdict and sentence, California abolished the diminished capacity defense in 1982. The verdict remains on the books in most other states, though, and in Federal courts, too.

In Review Criminal Competence and Responsibility

Main Concepts	Definition/description
Criminal competence	To be competent for trial, sentencing and execution, defendants must be able to understand court proceedings against them and assist their attorneys to prepare a defense. Defendants must also be shown to be competent at the time they confess to a crime, act as their own attorney, and choose not to invoke an insanity defense.
Methods for assessing competence	Mental status interview and specialized competency screening tests.
The insanity defense	Allows verdict of not guilty by reason of insanity (NGRI), thus avoiding imprisonment. To be found NGRI, defendants must be judged—at the time of the crime—to have had a serious mental illness that prevented them from understanding the wrongfulness of their actions or conforming their behavior to the law.
Methods for assessing sanity	Review of life history records, unstructured interviews with family and the defendant, structured interviews, intelligence tests, objective and projective personality tests, neuropsychological testing, and brain scans.
Insanity defense	Some states allow a verdict of guilty but mentally ill

reforms	(GBMI) for defendants who claim insanity. Defendants found GBMI go to prison and are supposed to receive treatment there. Some states allow defendants who claim insanity to also claim diminished capacity to tell right from wrong. If successful, the seriousness of the charge against the defendant may be reduced.

Test Yourself

1. Defendants who are not competent to stand trial for serious crimes are typically sent to a _______________ for _____________.

2. The core principle underlying the insanity defense is that defendants cannot be punished if they committed their crimes without ____________.

3. Expert witnesses in insanity defense trials can testify about a defendant's symptoms and likely diagnosis, but not about ___________.

You can find the answers in the Answer Key at the end of the book.

Assessing Psychological Status in Civil Cases

Section Preview Forensic psychologists become involved in civil cases when there are allegations, such as in workers' compensation trials, that a person has suffered psychological harm. Clinicians may also help the courts determine whether someone has sufficient mental capacity to make important decisions, such as making a will or selling property.

Tort law provides a mechanism for individuals to seek redress for the harm they have suffered from the wrongful acts of another party. It thus differs from *criminal law* which—acting on behalf of society as a whole—prosecutes defendants for wrongful behavior and seeks to punish them in an attempt to maintain society's overall sense of justice. When plaintiffs in civil cases sue defendants for causing harm to them and/or their property, the lawsuits are known as *tort actions*.

Assessing Psychological Damage in Tort Cases

Many kinds of behavior can constitute a tort. Slander and libel are torts, as are cases of medical malpractice, the manufacture of defective products resulting in personal injury, and intentional or negligent behavior producing harm to another person. When clinical psychologists conduct assessments with civil plaintiffs, they typically perform an evaluation that, like most clinical assessments, includes a social history, a clinical interview, psychological testing, interviews with others, and a review of available records. Based on these data, the clinician will reach a decision about what, if any, psychological problems the plaintiff might have. This aspect of forensic evaluation is not much different from what a clinician might do with any client, whether or not the client is involved in a lawsuit.

The far more difficult additional question the clinician must answer is whether the psychological problems identified were caused by the tort, were aggravated by the tort, or existed prior to the tort. There is no established procedure for answering this question, so most clinicians try to locate all clinical records and other sources of data that might help establish the point in time at which any diagnosed disorder first appeared. When plaintiffs allege that they were targeted for harassment or some other intentional tort because the defendants knew they had a psychological problem that made them especially vulnerable, the clinician must take this prior condition into account in reaching conclusions about the effects of the tort. Sometimes people allege that a specific kind of mental harm resulted from a defendant's negligence.

Workers’ Compensation Cases

When a worker is injured on the job, the law provides for the worker to be compensated, but it does so via a streamlined system that avoids the necessity of proving a tort. This system, known as *workers’ compensation law*, is in place in all 50 states and in the federal government. In workers’ compensation systems, employers contribute to a fund that provides workers’ compensation insurance; they also waive their right to blame the worker or some other individual for a worker’s injury. For their part, workers give up their right to pursue a tort against their employers; the award they receive is determined by the type and duration of the injury and the amount of their salary at the time of the injury. Workers can seek compensation for: (a) physical and psychological injuries sustained at work; (b) the cost of the treatment they receive for their injuries; (c) lost wages; and (d) the loss of future earning capacity.

Because psychological injuries or mental disorders arising from employment can be compensated, clinical psychologists are often asked to evaluate injured workers and render an opinion about the existence, cause, and implications of any mental disorders that might appear in a given case. Claims for mental disability usually arise in one of three ways.

First, a physical injury or job-related threatening event may contribute to the onset of a mental disorder and psychological disability. A common pattern seen in these *physical–mental* cases is that a worker sustains a serious physical injury—a broken back or severe burns, for example—that results in chronic pain. As the pain continues, the worker begins to experience psychological problems, usually depression and anxiety. These problems

worsen until they become full-fledged mental disorders, resulting in further impairments in overall functioning.

The second work-related pathway to mental disability is for an individual to suffer a traumatic incident at work or to undergo a long period of continual stress that leads to psychological difficulties. The night clerk at a convenience store who is the victim of an armed robbery and subsequently develops posttraumatic stress disorder would be an example of such *mental–mental* cases, as would the clerical worker who, after years of overwork and job pressure, experiences an anxiety-related disorder.

In a third kind of case, known as *mental–physical*, work-related stress is blamed for the onset or worsening of a physical disorder, such as high blood pressure or asthma. Many states have placed special restrictions on these types of claims, and psychologists are seldom asked to evaluate them.

In recent years, the number of psychological claims arising in workers' compensation litigation has increased dramatically. In the 1980s, stress-related mental disorders became the fastest-growing occupational disease category in the United States (Hersch & Alexander, 1990), with claims more than doubling from 1985 to 1990. Stress-related workers' compensation claims remain high in both public and private-sector occupations (Macklin, Smith, & Dollard, 2006).

Clinical psychologists are also heavily involved in assessments related to benefits not governed by workers' compensation law. This is largely because so many military veterans who returned from service in Iraq and Afghanistan report posttraumatic stress disorder and/or cognitive impairment arising from traumatic brain injury (Tanielian & Jaycox, 2008). Indeed, more than 20% of all military veterans are receiving compensation for posttraumatic stress disorder—a figure that has tripled in the last 10 years

(Shane, 2017). The Veterans Administration provides guidelines to clinical psychologists for performing the evaluations necessary for these veterans to receive benefits and treatment. The initial evaluation includes a review of: (a) the veteran's medical history, pre-military history (including family environment, family psychiatric history, history of juvenile delinquency and adult criminal infractions, and exposure to enumerated traumatic stressors); and (b) military history and post-military psychosocial adjustment, with emphasis on work history, encounters with the law, substance abuse, and suicide attempts. A clear description of the specific traumatic stressors encountered in the military must be included. After assembling these detailed histories, the clinician must conduct a mental status exam as discussed above, perform any psychometric testing deemed appropriate, and assess PTSD using DSM criteria. (Veterans Administration, 2007).

Civil Competencies

In our earlier discussion of clinical psychologists' involvement in assessing competence, we focused mainly on competence of defendants to stand trial in criminal proceedings, but the question of mental competence can be raised in several noncriminal situations as well. These other situations involve assessment of *civil competencies*.

Questions of **civil competency** focus on whether an individual has the capacity to understand information that is relevant to making a decision (about the pros and cons of selling a house, for example) and then making an informed choice about what to do. Civil competency questions are commonly asked about whether a person is capable of managing personal financial or medical affairs, such as making decisions about accepting or refusing medical or psychiatric treatment, or executing a will that directs how property should be distributed to heirs or other beneficiaries. If the person is found incompetent to perform these tasks, a legal guardian may be required (Rothke, Demakis, & Amsbaugh, 2019).

Civil competency
A finding that an individual has the capacity to understand information relevant to making a decision and make an informed choice.

The legal standards used to define civil competence have evolved over many years, but scholars who have studied this issue agree that four abilities are essential to competent decision-making (Appelbaum & Grisso, 1995). A competent individual is expected to be able to: (a) understand basic information relevant to making a decision; (b) apply that information to a specific situation to anticipate the consequences of various choices that might be made; (c) use logical, rational thinking to evaluate the pros and cons of various strategies and decisions; and (d) communicate a personal decision or choice about the matter under consideration. The specific abilities associated with each of these general criteria vary, depending on the decision the person has to make. Deciding whether to have risky surgery demands different kinds of information and thinking processes than does deciding whether to leave one’s estate to one’s children or to a charitable organization.

Can people with serious mental disorders make competent treatment decisions? Do their decision-making abilities differ from people who do not have such disorders? These questions were the focus of the MacArthur Treatment Competence Study (Appelbaum & Grisso, 1995, 2004), which led to the development of a series of structured interview measures to assess the four basic abilities mentioned above. Standardized interviews were conducted with three groups of patients—those with schizophrenia, major depression, or heart disease—and with groups of healthy people who were demographically similar to the patient groups (Grisso & Appelbaum, 1995). Patients hospitalized with mental illness had more deficits in decision-making than did the medically ill or non-patient controls, more so for patients diagnosed with schizophrenia than with depression. However, after two weeks in the hospital, schizophrenia patients showed gains in their ability to make treatment decisions. The study concluded that patients hospitalized with a

mental illness should not be presumed to be unable to make treatment decisions, nor should it be presumed that the mental illness has no effect on decision making.

What about decisions related to end-of-life matters? In the case of *Cruzan v. Director, Missouri Department of Health*, (1990) the U.S. Supreme Court recognized that states may allow patients to formalize their desire not to receive life-sustaining medical treatment should they become incapacitated or terminally ill. Accordingly, clinical psychologists and other mental health professionals may be called upon to determine a person's competence to make these momentous decisions, known as *advance medical directives*. In general, these competency assessments reveal that most patients, even those with a terminal medical condition, have a high degree of autonomy in accepting or rejecting a variety of treatments and health care provisions (Cantor, 1998; Rich, 1998). Competency assessments are particularly vital in cases of people who wish to end their lives through assisted suicide (Lagay, 2003). As you might expect, U.S. states where physician-assisted suicide is legal all require assessments to confirm that people who wish to pursue this option are of sound mind and free of serious mental illness.

In Review Assessing Psychological Status in Civil Cases

Targets of Civil Forensic Assessment	**Examples**
Psychological damage in tort cases	Using interviews and tests to identify a plaintiff’s psychological problems and judge whether these problems existed prior to the tort, or was caused or aggravated by the tort.
Job-related damage in worker’s compensation cases	Using interviews and tests to identify possible links between on-the-job injury and later psychological problems, between a traumatic work experience and later psychological problems, and between on-the-job stress and later psychological problems.
Civil competency	Using interviews and tests to evaluate four aspects of a person’s competency to make important financial, legal, social, and health-related decisions, including the decision to end one’s life. These aspects are: (a) understanding basic information about the decision; (b) applying information to anticipate consequences; (c) logically evaluating pros and cons; and (d) communicating one’s decision.

Test Yourself

1. Civil lawsuits in which plaintiffs allege that defendants caused harm to them or their property are called ___________.

2. Military psychologists are commonly involved with conducting forensic assessments in patients who claim harm stemming from ___________________.

3. Competency to make health-related decisions is especially important in states that allow _______________.

You can find the answers in the Answer Key at the end of the book.

Psychological Autopsies and Criminal Profiling

Section Preview Psychological autopsies are conducted to help determine whether, for instance, a person's death resulted from suicide, accident, or homicide. Criminal profiling occurs when a crime, or a series of crimes, has been committed but the identity of the person(s) who committed it is unknown. Clinicians acting as profilers should use psychological science to describe the most likely characteristics of the criminal, but they often do not.

As already mentioned, most forensic assessments, like most other clinical assessments, include interviewing, observing, and testing living individuals. Sometimes, though, forensic clinicians may be called upon to give opinions about a deceased person's state of mind prior to death. In such cases, the clinician obviously must conduct the evaluation without that person's participation. These postmortem psychological evaluations are known as *psychological autopsies* or equivocal death analyses (Botello, Noguchi et al., 2013).

Psychological Autopsies

The first psychological autopsies were conducted in the 1950s, when a group of social scientists in Los Angeles began assisting the County Coroner’s Office in determining whether suicide, murder, or accident was the most likely cause of death in certain equivocal cases. Since then, psychological autopsies have become commonplace, especially when insurance companies want to know whether their life insurance policyholder committed suicide, in which case death benefits would be denied. Psychological autopsies are also used: (a) in workers’ compensation cases when an employee’s family claims that stressful working conditions or work-related trauma contributed to their relative’s suicide or accidental death; (b) to decide whether a deceased individual had the mental capacity necessary to competently execute or modify a will; and (c) to support the argument made by criminal defendants that the person they allegedly killed died by suicide, not homicide.

There is no standard format for conducting psychological autopsies, but most clinicians rely heavily on documents and other life records that a person leaves behind, as well as on interviews with those who knew the decedent (Murthy, 2010). Some clinicians concentrate on evidence from the time just before the person’s death. What was the person’s mood? How was the person doing at work? Were there any pronounced changes in the person’s behavior? Clinicians who take a psychodynamic approach look for evidence about family dynamics and personality traits appearing early in the person’s life. As a child, how did the person interact with parents or other caregivers? What was the individual’s approach to school? To competition with peers?

How valid are psychological autopsies—that is, do they accurately portray a person's state of mind at the time of death? There are certainly reasons to doubt their validity. For one thing, most of the assessment information comes "secondhand," because the person about whom inferences are to be made is not available for interviewing or testing. Further, as noted in Chapter 4, information obtained through third-party interviews may be distorted by memory lapses or by efforts to describe a person in an especially good, or bad, light. There is very little research on the validity of psychological autopsies (Dattilio, 2006; Murthy, 2010), partly because the deceased person's "true" state of mind prior to death is unknown and unknowable, and thus cannot be compared to conclusions drawn later by clinicians. This problem may be partially solved if, in future studies, researchers were to assess how well-reputed experts perform when given psychological autopsy information about cases in which the cause of death appears ambiguous but is actually known. Studying the accuracy of these experts' conclusions, and the reasons behind them, may go a long way toward establishing the validity of psychological autopsies.

In the absence of better research evidence, judges have had mixed reactions to psychological autopsy evidence. In cases involving workers' compensation claims and questions of whether insurance benefits should be paid, the courts have usually admitted psychological autopsy testimony. They have been much more reluctant to do so in criminal cases and in cases involving the question of whether a person had the mental capacity to draft a will (Ogloff & Otto, 2003), because these cases may require psychologists to offer testimony about the ultimate issue to be decided in a case. As noted earlier and discussed further later, that sort of testimony is usually not permitted.

Criminal Profiling

In some ways, psychological autopsies resemble a technique known as *criminal profiling*. In both cases, clinicians draw inferences about an individual's motives and state of mind based on life records or other data a person has left behind. In psychological autopsies, however, the identity of the person being assessed is known, and the question is what they did, and why. In criminal profiling, the person's behavior is known, and the question is "who did it?"

One of the first examples of successful criminal profiling came in 1957, with the arrest of George Matesky, the so-called "Mad Bomber" of New York City. After trying for over a decade to identify the person responsible for more than 30 bombings in the area, the New York police consulted Dr. James Brussel, a local psychiatrist. Brussel examined pictures of the bomb scenes and analyzed letters sent to police by the bomber. Based on these data, Brussel advised the police to look for a heavyset, middle-aged, Eastern European, Catholic man who was single and lived with a sibling or an aunt. Brussel also concluded that the man loved his mother and valued neatness. He even predicted that when the man was found, he would be wearing a buttoned double-breasted suit. When the police finally arrested Matesky, this profile turned out to be uncannily accurate, right down to the suit (Brussel, 1968).

The major source of research and development on criminal profiling is the FBI's Behavioral Analysis Unit. When it was formed, this unit included law enforcement profilers who were trained in behavioral science and who worked with a small number of psychologists and other mental health

professionals. Their work was primarily to provide profiles of serial and mass killers. The unit's mission has now expanded considerably. Since 2011 it has been a part of the FBI's National Center for Analysis of Violent Crime (NCAVC), and consists of units devoted to (a) counter-terrorism, arson, and bombing; (b) threats, cybercrime, and public corruption; (c) crimes against children; (d) crimes against adults; and (e) research, strategy, and training.

Though many experts agree that different kinds of crimes, victims, and crime scenes do correlate with certain offender characteristics, investigators must still take care to avoid uncritical acceptance of a profiler's conclusions (Turvey, 2012). For one thing, in contrast to the "mad bomber" case, inaccurate profiles are quite common, partly because too many profilers rely more on their intuition and "gut hunches" than on findings from well-replicated psychological science. Second, many of the evaluation studies have been conducted by FBI profilers themselves and have focused on a rather small number of cases. Third, the concepts and approaches used by profilers have often not been objectively and systematically defined (Bartol & Bartol, 2008). In fact, a survey of 152 police psychologists found that 70% of them had serious questions about the validity of crime scene profiling (Bartol, 1996), and for good reason. To take one example, after a bomb exploded at the 1996 Olympics in Atlanta, the police almost immediately —and incorrectly, as it turned out—focused their suspicions on Richard Jewell, an Olympic Park security guard. Jewell was singled out because he fit an FBI profile for this kind of bombing; he was a white, single, middle-aged male who craves the limelight, sometimes as a police officer "wannabe." In this case, the profile was wrong; he had nothing to do with the bombing. Cases like these explain why the FBI's Behavioral Analysis Units are constantly working to improve the accuracy of profiling by basing the

process on the latest scientific research (Federal Bureau of Investigations, 2014). Fourth, there is little or no evidence that professional criminal profilers possess special, let alone, distinctive expertise. Several studies have shown their profiles to be no better, or only a little better than those created by college chemistry students or other individuals with minimal knowledge of criminal behavior (Kocsis, Hayes, & Irwin, 2002; Snook et al., 2008). Fifth, and perhaps most important, as we mentioned in Chapter 3, decades of psychological research demonstrate that statistical formulas based on established data tend to perform at least as well, and often better, than clinical predictions based on intuition, gut hunches, and personal experience (Grove et al., 2000; Meehl, 1954). This evidence raises the question of why we need criminal profilers to identify criminal suspects. Computerized prediction formulas generated on the basis of large bodies of data on the characteristics of various kinds of crimes and criminals are likely to be at least as effective, and much less expensive and time-consuming.

In Review Psychological Autopsies and Criminal Profiling

Forensic Activity	**Assessment Goals**	**Examples**
Psychological autopsies	Judging a person's state of mind prior to death.	Did a person die by suicide, homicide, or accident? Was a person competent to make or change a will just before death?
Criminal profiling	Suggest the characteristics of the person or people responsible for a crime or series of crimes.	Advising law enforcement agencies about the likely age, sex, ethnicity, education, living situation, occupational history, and other attributes of the person behind serial killings.

Test Yourself

1. Because it involves trying to understand a person's past state of mind, conducting a psychological autopsy is most similar to what other kind of forensic assessment?

2. Is there a standard format for conducting psychological autopsies, and if so, what is it?

3. The government agency most involved with criminal profiling is the _________.

You can find the answers in the Answer Key at the end of the book.

Child Custody and Parental Fitness

Section Preview More clinical psychologists are involved in child custody cases than in any other area of forensic work. When parents decide to end their relationship, clinicians often conduct evaluations of the parents, and their children, to help the courts decide what custody arrangements are in the children's best interests.

One of the fastest-growing areas for clinicians in forensic psychology is the assessment of families in crisis, particularly when parents are ending their relationship.

Child Custody Disputes

In these situations, the clinician is usually asked to conduct a **child custody evaluation** and to offer recommendations to help a court settle disputes over which parent can best meet the children's needs and which, therefore, should be granted custody of them. The growth in these assessment activities is attributable, first, to the fact that about half of all marriages in the United States end in divorce, and that many unmarried couples with children end their relationships, too. So child custody questions arise for millions of families every year; indeed, it is estimated that 40% of children will have experienced parental divorce or separation by the age of 16 (Fabricius et al., 2010). Second, the courts' preference for maternal custody, which reigned during most of the 20th century, gave way in the 1980s in most U.S. states to gender neutral laws that put parents on equal footing, in principle at least. The same is true in married or unmarried same-sex couples with children. So today, gender plays a less important role in custody decisions; courts now routinely want to know mainly about the parenting abilities of each parent before deciding about custody (Fabricius, Braver, Diaz, & Velez, 2010).

Child custody evaluation

A clinical assessment designed to make recommendations to help a court settle disputes over which parent should be granted custody of children.

Most states permit two kinds of custodial arrangements: joint custody or sole custody. When sole custody is granted, it is both legal and physical. This means that one parent is given both the right to physically keep the children and the legal right to make decisions about their education, health care, and other aspects of their welfare. In joint custody, the legal and physical rights can be shared or divided. In some cases, for example, the parents may have joint legal custody, but only one parent has physical custody, while the other has visitation rights. In other cases, the parents may share both legal and physical custody, meaning that the children live with each of them on a schedule that has the children switching homes as often as every week. Compared with sole custody, joint or shared legal and physical custody distributes the frequency of child contact more evenly between the two parents, leads to more interaction between the parents, generates more demands for cooperation concerning their children, and results in more variation in caregiving arrangements (Clingempeel & Repucci, 1982).

Clinicians conduct custody evaluations under any of three sets of circumstances. In some cases, a judge appoints a clinician to perform a custody evaluation whose results will be available to both parents. In others, each parent retains a different expert to conduct independent evaluations, and in still others, the parents agree to share the cost of hiring one expert to conduct a single evaluation (Weissman, 1991). Most informed observers, including attorneys, prefer either the first or third option because these options tend to minimize the hostilities and adversarial pressures that usually arise when different experts are hired by each side (Keilin & Bloom, 1986).

Although the methods used in custody evaluations vary a great deal depending on the specific issues in each case, the American Psychological Association (2010a) and the American Academy of Matrimonial Lawyers

(2011) have published guidelines for conducting them. Most evaluations include a summary of the family's clinical and social history, standardized testing of the parents and the children, observation of parent–child interactions, interviews with individuals who have had opportunities to observe family members, and a review of documents that might be relevant to the case, including medical records of children and parents.

These evaluations typically take a total of about 30 hours. A substantial amount of this time is spent interviewing and observing the parties in various combinations. Most clinicians conduct individual interviews with each parent and each child, and observe each parent interacting (separately) with each child. As for formal psychological testing, the MMPI-2 is the test most often used with parents. Intelligence tests and projective personality tests are the most common instruments used with children, although the same concerns mentioned earlier (and in Chapter 5) about the reliability and validity of projective measures also apply in relation to custody assessments (Erickson, Lilienfeld, & Vitacco, 2007). An increasing number of clinicians report also using one or two instruments specifically designed for child custody evaluations: the Bricklin Perceptual Scales and the Ackerman–Schoendorf Scales for Parent Evaluation of Custody (ASPECT) (Nicholson, 1999). The most common recommendation to come out of custody evaluations is for limited joint custody, in which parents share the decision-making, but one parent maintains primary physical custody. Single-parent custody without visitation is the least commonly recommended option.

Do children adapt and function better when raised in joint custody or sole custody arrangements? One might expect it could go either way, because although joint custody allows children to maintain close ties to both parents, sole custody simplifies custodial arrangements and minimizes children's

confusion over where they live. There is not enough research evidence available to reach final conclusions about the wisdom of various custody recommendations (Emery, Otto, & O'Donohue, 2005), though it appears that joint or shared custody tends to be associated with better outcomes in terms of the emotional, behavioral, and psychological well-being of children and parents, and the quality of the parental relationship (Baude, Pearson, & Drapeau, 2016; Nielsen, 2014). This latter point is important because it appears that the quality of the relationship between now-separated parents is more important to the adjustment of their children than whether the children are raised in sole custody or joint-custody arrangements (Crosbie-Burnett, 1991; Emery, 1982; Hetherington & Arasteh, 1988; Pruett & Barker, 2013).

Evaluations regarding child custody and parental fitness are among the most ethically challenging and clinically difficult of all forensic cases. For one thing, the emotional stakes are extremely high, and both parents are often willing to spare no expense or tactic in the battle over who will win custody. Associated with this conflict is the fact that the children are usually forced to live, for months if not years, in an emotional limbo in which they do not know with whom they will eventually live, where they will be going to school, or how often they will see each parent.

Second, to conduct a thorough family assessment, the clinician must evaluate the children, both parents, and, when possible, other people who have observed the family's interaction. Often, not all parties agree to such evaluations or do so only under duress, a fact that often creates a lengthy and unfriendly assessment process. Third, to render an expert opinion, the clinician must possess a great deal of knowledge not only about the children and parents being evaluated but also about infant–parent attachment, child development, family systems, the effects on children of their parents'

separation or divorce, adult and childhood mental disorders, and several different kinds of testing (see Chapter 11).

The assessment situation is complicated, too, by changes in traditional definitions of a "family." Increasing acceptance of variability in lifestyles has forced clinical psychologists and legal scholars to confront questions about whether parents' sexual orientation or ethnicity should have any bearing on custody and adoption decisions.

Finally, child custody evaluations are usually highly adversarial processes in which each side is likely to challenge the procedures or opinions of any expert with whom it disagrees. Clinicians who conduct custody evaluations must therefore brace themselves for all sorts of attacks on their clinical methods, scholarly competence, personal character, and professional ethics (Pepiton et al., 2014; Wittmann, 2012 To guard against these attacks, and to ensure that evaluations are done properly and professionally, clinicians should follow the American Psychological Association's (2010a) *Guidelines for Child Custody Evaluations in Family Law Proceedings* listed in Table 14.2.

Table 14.2 Guidelines for Child Custody Evaluations in Family Law Proceedings

I. Orienting Guidelines: Purpose of a Child Custody Evaluation

1. The primary purpose of the evaluation is to assess the psychological best interests of the child.

2. The child's welfare is paramount.

3. The evaluation focuses on parenting attributes, the child's psychological needs, and the resulting fit.

II. General Guidelines: Preparing for a Child Custody Evaluation

1. Psychologists strive to gain and maintain specialized competence.

2. Psychologists strive to function as impartial evaluators.

3. Psychologists strive to engage in culturally informed, nondiscriminatory evaluation practices.

4. Psychologists strive to avoid conflicts of interest and multiple relationships in conducting evaluations.

III. Procedural Guidelines: Conducting the Child Custody Evaluation

1. Psychologists strive to establish the scope of the evaluation in a timely fashion, consistent with the nature of the referral question.

2. Psychologists strive to obtain appropriately informed consent.

3. Psychologists strive to employ multiple methods of data gathering.

4. Psychologists strive to interpret assessment data in a manner consistent with the context of the evaluation.

5. Psychologists strive to complement the evaluation with the appropriate combination of examinations.

6. Psychologists strive to base their recommendations, if any, upon the psychological best interests of the child.

7. Psychologists create and maintain professional records in accordance with ethical and legal obligations.

Custody Mediation

Because divorce or parental separation is such a potent stressor for many children and because protracted custody battles tend to leave a trail of emotionally battered family members in their wake, clinicians are devoting increasing attention to helping parents and children cope with these transitions or to finding alternatives to custody battles (Nurse & Thompson, 2013).

One result is the availability of *custody mediation* services designed to take the place of adversarial court procedures. The clinician's job as the mediator is to try to help the parents to agree on a resolution of their differences by providing a safe environment for communication and by helping them to explore various options (Emery, 2012).

To assess the impact of mediated versus adversarial child custody procedures, Robert Emery and his colleagues conducted a study in which divorcing couples agreed to be randomly assigned to settle their custody disputes through either mediation or litigation. They found that although mediation took only an average of 6 hours, it was associated with surprisingly positive results even at 12-year follow-up (Emery, 2012). Compared to families who litigated their custody disputes, those who had been assigned to mediation showed less interparental conflict, more involvement with children by the nonresidential parent, and better parenting skills by the nonresidential parent. Given the fact that lower levels of interparental conflict and higher levels of involvement with well-functioning nonresidential parents are generally associated with positive outcomes for children, it is not surprising to find that youngsters in the mediation group did better at long-term follow-

up than those in the litigation group. Note, however, that mediation may be counterproductive or harmful when domestic violence or substance abuse has led to one partner having more power in the relationship.

Psychologists facilitate mediation by helping the parties to emotionally accept the divorce or separation, resolve disputes, and establish a stable co-parenting relationship (Nurse & Thompson, 2013). Indeed, a new role is evolving for psychologists in custody disputes, namely to teach divorced or separated parents how to co-parent their children. Known as *parenting coordinators*, these clinicians help clients address parenting issues by focusing on the developmental and emotional needs of the children and to resolve among themselves issues that otherwise would have to be decided by a judge in an adversarial setting (Bailey, 2005). A main goal of this kind of clinical work is to focus the parents' attention on the welfare of the children rather than on fighting with each other and using the children as pawns in their disputes. The parents may welcome this kind of assistance, but there is not yet enough objective evidence available to determine how effective it is in significantly improving the quality of co-parenting arrangements (Deutsch, Misca, & Ajoku, 2018).

Termination of Parental Rights

In rare cases, courts may terminate parents' rights to have any contact with a child if the judge finds that such contact will be detrimental to the child's mental or physical welfare. Upon such a finding, the child is placed in the custody of the local department of child welfare, which will try to find a home for the child in either permanent foster care or an adoptive home. In most termination of parental rights cases, the agency asking for the termination will provide the court with an evaluation conducted by a clinical psychologist. Clinicians' evaluations address the state's legal requirements (found in statutes and case decisions) for termination. The definition of parental unfitness varies among states and is defined by statute, but Virginia provides a typical example; a parent must: (a) have abandoned the child for more than six months; (b) have been convicted of a murder or extreme physical harm to another child; (c) be physically or mentally unfit to care for the child in spite of all efforts of child welfare authorities to keep the child with the parent; or (d) have not remedied the situation that caused the child to first come in contact with child welfare workers (these latter cases typically involve physical or sexual child abuse, gross neglect of the child's physical or medical well-being, and parental drug or alcohol addiction). Sensitive due process issues arise in the case of parents with substance abuse, mental illness, and cognitive impairment (Azar, Benjet, & Kuersten-Hogan, 2003). Parents whose rights are under threat of being terminated may introduce their own psychological reports, but since there are usually no juries in parental termination cases, presiding judges alone decide how much weight to give these reports. In most states, proof of parental unfitness must be "clear and

convincing," which is a lower standard than the "beyond a reasonable doubt" that exists in criminal cases, but higher than the civil standard of "a preponderance of the evidence."

As with child custody cases, evaluations and testimony related to parental fitness cases can be complex and contentious, and clinicians involved in them may face several practical and ethical dilemmas. To assure that their practices remain professional and in the best interests of the public and the law, forensic psychologists adhere not only to the American Psychological Association's general ethical guidelines described in Chapters 2, 3, and 15, but also to its *Guidelines for Psychological Evaluations in Child Protection Matters* (American Psychological Association, 2013a).

In Review Child Custody and Parental Fitness

Forensic Activity	**Goals**	**Examples**
Child custody evaluations	Offer recommendations, when parents decide to end their relationships, about granting joint or sole custody of children and which parent can best meet children's needs.	Collecting clinical, medical, and social history data, interviews of parents and children, observation of parent–child interactions, personality testing of parents, IQ and personality testing of children, specialized testing of custody-related parental characteristics, and interviewing people who know the family well.
Custody mediation	Helping parents find alternatives to taking child custody conflicts to court.	Create a safe environment in which parents can discuss their differences on neutral ground, explore a variety of custody arrangements, and reach an agreement.
Parenting coordination	Provide guidance on the development of co-parenting skills.	Therapy-like sessions in which parents are helped to understand and support the emotional and developmental needs of

		their children; designed to prevent children from being used as “pawns” in conflicts between the parents.
Parental rights termination evaluations	Provide clinical information bearing on the degree to which parents’ behavior and children’s status meet the legal criteria for losing parental rights.	Collecting family history data, conducting interviews and tests with parents and children.

Test Yourself

1. After conducting child custody evaluations, forensic clinical psychologists tend to recommend ______ custody rather than ______ custody.

2. The _______ is the most common adult personality test used in child custody evaluations.

3. Forensic clinical psychologists’ main goal in custody evaluations and mediation is to promote arrangements that are in the best interests of __________.

You can find the answers in the Answer Key at the end of the book.

Mental Health Experts in the Legal System

Section Preview Most of the forensic assessment practices we have described require clinicians to testify in court as expert witnesses on a wide range of issues. In doing so, they benefit from knowing how the legal system works and from using empirically supported practices.

Testifying as an expert witness is one of the most visible of clinical psychologists' forensic activities. Clinical psychologists (and psychiatrists) have testified in some of the most notorious criminal trials in U.S. history, including those of all the assassins and serial killers we described earlier, but they testify in many other kinds of cases as well (see Table 14.3). By legal definition, an **expert witness** is someone with scientific, technical, or other specialized knowledge acquired by means of experience, training, or education who may testify in the form of an opinion or otherwise if four main requirements are met:

1. An expert testifies at the discretion of the judge when the judge believes that the expert's scientific, technical, or other specialized knowledge will help the trier of fact (typically jurors) to understand the evidence or to determine a fact at issue.

2. The expert's testimony must be based on sufficient facts or data.

3. The expert's testimony must be based on reliable and accepted principles and methods within the expert's field. In the legal field, unlike in psychology, the term "reliable" means "based in sound science."

4. The principles and methods used or referred to by the expert must be applicable to the facts or data in the case.

Expert witness
Someone with scientific, technical, or other specialized knowledge who may give court testimony in the form of an opinion.

These standards are codified in Federal Rule of Evidence 702, Testimony by Expert Witnesses, which reflects litigation in the 1990s concerning the reliability of scientific expert testimony. Although the Federal Rule applies only to trials in federal court, the majority of states also apply its standards. Other states have differing requirements for the admissibility of expert testimony, but require, at least, that the testimony be based on established and accepted scientific evidence (e.g., Davies, 2005; Shuman & Sales, 2005).

Table 14.3 Topics for Expert Psychological Testimony
As described earlier, clinical psychologists testify as expert witnesses about a criminal defendant's competence to stand trial and/or mental state at the time of a crime, and about psychological damage in civil trials. Here are some additional topics for their expert testimony.

Topic of Testimony	Main Question Addressed in Testimony
1. Sentencing	What are the prospects for the defendant's rehabilitation? What deterrent effects do certain sentences have?

2. Eyewitness identification	What factors affect the accuracy of eyewitness identification?
3. Civil commitment	Does a mentally ill person present a danger, or threat of danger, such that hospitalization is necessary?
4. Negligence and product liability	How do environmental factors and human perceptual abilities affect an individual's use of a product?
5. Trademark litigation	Is a certain product name or trademark confusingly similar to that of a competitor?
6. Discrimination	Is there psychological evidence that equal treatment is being denied or that certain procedures and decisions discriminate against women and minorities in the schools or in the workplace?
7. Guardianship and conservatorship	Does an individual possess the necessary mental ability to make decisions concerning his or her health and general welfare?
8. Professional malpractice	Did a mental health professional's conduct fail to meet the standard of care owed to the client?
9. Mitigating psychosocial factors in litigation	What are the effects of pornography, violence, domestic partner abuse, and the like on the behavior of litigants who claim that their conduct was affected by one of these influences?

The testimony of experts is limited by law to descriptions of parties' symptoms, behavior, and demeanor; explanation of the evaluation and assessment instruments used; and opinions about the party's mental status, including a diagnosis of mental disorder. As already mentioned, experts are *not* allowed to offer an opinion as to whether or not a defendant is competent to stand trial or was sane at the time of an offense, whether a party was competent to make a will, which of two parents would make a better custodian of children, or any other opinion that goes to the ultimate issue before the court. Doing so would be drawing a legal conclusion that usurps the prerogative of the judge and jury to apply the law to the facts and opinions given by the expert (Cassel & Bernstein, 2007).

Psychologists are frequently called to testify as expert witnesses partly because, as shown in Table 14.3, there are so many topics about which they can testify. As psychological scientists learn more about human behavior, attorneys are likely to find their research results increasingly helpful in court cases. The media usually focus on testimony concerning criminal competence and responsibility, but testimony about these topics is relatively rare compared with those involving child custody, workers' compensation, tort, and discrimination cases.

Yet psychological expert testimony has often been criticized as lacking in reliability, validity, propriety, and usefulness. Former federal appellate judge David L. Bazelon (1974), a supporter of legal rights for mentally ill people, once complained that "in no case is it more difficult to elicit productive and reliable testimony than in cases that call on the knowledge and practice of psychiatry." This view was echoed by Warren Burger (1975), a former Chief Justice of the Supreme Court, who chided experts for the "uncertainties of psychiatric diagnosis." The value of psychologists' expert

testimony, too, has long been challenged (Bonnie & Slobogin, 1980; Goleman, 1988; Ennis & Litwack, 1974; Morse, 1978; Yuille, 1989), and there are well-known guidebooks devoted entirely to the subject of how to cross-examine psychologists (e.g., Campbell & Lorandos, 2012; Faust, 2011). Such criticism has led to calls for the development of clearer scientific standards of practice in forensic mental health (Heilbrun et al., 2008), a call that has been recently answered (American Psychological Association, 2013b).

Tightening the evidentiary standards, as Federal Rule 702 and case decisions have done, forces psychological experts to address some of the concerns lawyers, judges, and appellate courts have had in the past (Smith, 1989), such as the fact that some of their opinions were not based entirely on valid research (Hoffman & Werboff, 2012). Nevertheless, judges and juries still must contend with the problems that arise when experts do a poor job of testifying and when attorneys who are not knowledgeable enough about psychology as a science fail to properly examine and cross-examine experts. These problems deprive judges and juries of the benefits of a well-presented and effectively challenged opinion; fact-finders cannot be enlightened by testimony they do not understand. Indeed, experts on expert testimony recommend that psychological expert witnesses should take the role of teachers and try to present complex concepts in simple terms, using charts, videos, photographs, and models to help jurors visualize and comprehend the material.

Another problem with psychological expert testimony is that juries are understandably confused and frustrated when opposing sides present experts who directly contradict each other. Faced with this “battle of the experts,” jurors tend to ignore them all and base their decision on nonexpert testimony

(e.g., Brekke et al., 1991). Scholars have provided several suggestions for reducing the overly adversarial nature of all kinds of scientific and technical expert testimony, including that of clinical psychologists. Among these suggestions are: (a) limiting the number of experts each side may introduce to testify about a given topic; (b) requiring that the experts be chosen from an approved panel of individuals reputed to be objective and highly competent; and (c) allowing testimony only from experts who have been appointed by a judge, not those hired by opposing attorneys. Published guidelines also help courts determine whether the testimony of experts is based on accepted professional practices (e.g., American Psychological Association, 2013b).

A number of scientific and professional organizations have come forward with proposals to aid the courts in finding skilled experts, an initiative supported by U.S. Supreme Court Justice Stephen Breyer (2000). The National Conference of Lawyers and Scientists, a joint committee of the American Association for the Advancement of Science and the Science and Technology Section of the American Bar Association, has developed a pilot project to test the feasibility of increased use of court-appointed experts in cases that involve technical issues. The project recruited a slate of candidates from scientific and professional organizations to serve as court-appointed experts in cases in which the judge decides that adversarial experts are unlikely to provide the information that is necessary for a well-reasoned resolution of the disputed issues. To further promote the appropriate use of scientific evidence in the courtroom, the National Research Council has compiled a Reference Manual for Scientific Evidence (National Academies of Science, 2011), now in its third edition.

In Review Mental Health Experts in the Legal System

The role of clinical psychologists as expert witnesses	Give opinions in court based on their general knowledge and experience, and on specific interview, test, and observational data.
Topics of psychological expert testimony	Criminal cases: evaluations of defendants' competency to stand trial, sanity at the time of a crime, likelihood of rehabilitation; degree of dangerousness. Civil cases: degree of plaintiff's psychological damage; competence to make or execute a will or make personal medical decisions; factors affecting consumers' use of manufactured products; likelihood that similar product names or trademarks will confuse consumers; opinion about the degree to which employees suffered discrimination at work; opinion as to whether a psychologist violated professional ethics; opinion about whether a plaintiff's exposure to violence or other environmental influences affected their behavior or psychological functioning. Civil and criminal: accuracy of eyewitness testimony.
Evaluation of testimony by mental health experts	**Pros:** Clinicians are mental health experts who can help judges and juries to make just decisions. The ever-growing knowledge coming from research and practice in psychological science

	allows clinicians to be helpful in an increasing number of legal areas. **Cons:** Not all expert witnesses base their testimony on the best-supported or latest psychological science and practice, and they may also be biased, especially if they are hired by one of the two sides in a court case rather than chosen by the court itself. Lawyers may not understand enough about psychological testimony to know the right questions to ask about it during cross-examination. When two or more mental health experts give conflicting testimony, judges and jurors may decide to ignore that testimony, even if some of it could be helpful.

Test Yourself

1. Clinical psychologists testify in _______ cases far more often than _______ cases.

2. The decision to call for or allow expert testimony in a trial is made by _______.

3. A psychologist who is asked to testify about the accuracy of eyewitness identification would probably be an expert on ________.

You can find the answers in the Answer Key at the end of the book.

Chapter Summary

Clinical psychologists are involved in forensic psychology, a specialty that applies mental health knowledge and expertise to questions about individuals involved in legal proceedings. The nature of forensic assessment depends on the questions being asked, but, like most clinical assessments, it often includes a social history, a clinical interview, psychological testing, a review of life records, and perhaps interviews with a variety of third parties.

Evaluating competence to stand trial requires assessment of whether defendants can understand the nature of their trial, participate in their defense, and consult with their attorneys. Most defendants referred for such evaluations are ultimately found competent. Defendants who plead not guilty by reason of insanity (NGRI) must present evidence that they lacked the state of mind (*mens rea*) necessary to be held responsible for a crime. Psychologists and other mental health experts evaluate these defendants to help judges and juries decide if the defendants meet the legal definition of insanity. This definition has changed over time and can vary from one state to another, but the essence of the term is that a defendant must be unable, because of a mental disease or defect, to understand the nature of a criminal act or to know that the act was wrong. A variety of reforms—including abolition of the insanity defense, further changes in the definition of insanity, and the advent of the guilty but mentally ill (GBMI) verdict—have been enacted to address criticisms of the insanity defense.

Psychologists often testify in tort lawsuits, where plaintiffs seek compensatory and punitive damages for wrongful acts they claim caused

them psychological harm. The psychologists' testimony concerns the nature, extent, and impact of that harm. Psychologists also conduct assessments designed to determine questions about civil competency, such as whether a person is capable of making decisions about financial affairs and medical or psychiatric treatment or disposition of assets in a will, or perhaps needs a guardian.

Clinicians involved in conducting psychological autopsies seek to determine the cause of a suspicious death, usually at the behest of courts and insurance companies, and often to rule out suicide. Psychologists with expertise in law enforcement may also be involved in criminal profiling, a practice that seeks to help find the perpetrator of especially heinous or serial crimes. The scientific evidence for the accuracy of criminal profiling is feeble.

Psychologists may conduct evaluations in worker's compensation and other employment-related cases. They are also involved in the assessment of returning war veterans' posttraumatic stress disorder (PTSD) and cognitive impairments that can affect these veterans' ability to return to duty and/or to receive benefits and treatment.

Clinical psychologists who assess families in crisis continue to be in high demand. These psychologists offer opinions about the fitness of separating or divorcing parents to retain custody of their children and whether joint custody, sole custody, or some other arrangement would be best for the children. Many clinicians are also involved in efforts to mediate, rather than litigate, custody battles. Some act as parenting coordinators who help divorced or separated parents agree on parenting issues.

Although expert testimony by psychologists is common, some critics question its reliability, validity, propriety, and usefulness. The reputation of

psychological expert testimony may be enhanced by a variety of reforms, including setting standards for practice, enactment of procedural rules that govern the type and limits of expert testimony, and creation of registries of experts who will serve the court itself, not individual parties.

15

Training and Practice Issues in Clinical Psychology

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Contents

Professional Training
Professional Regulation
Professional Ethics
Professional Independence
Professional Multicultural Competence
The Future of Clinical Psychology

Chapter Preview

This chapter describes professional issues within clinical psychology, including models for professional training, professional regulation, ethics, professional independence, and multicultural competence. Based on historical and current forces in the field, we also make predictions about where clinical psychology is heading in the future.

We hope that the previous chapters have made it obvious that clinical psychologists take professional integrity very seriously. The field has changed significantly over the past 125 years, but the goals of helping people and furthering scientific understanding have remained intact for clinical psychologists worldwide.

Relatively recent changes in the field, including the increasing need for mental health services, the proliferation of managed-care systems, expanding possibilities for prescription privileges for clinical psychologists, the focus on multiculturalism and diversity, and the intense focus and debate about evidence-based practice, all suggest that clinical psychology has entered a new era. The field looks very different today than it did just 30 years ago, and we expect it to continue changing over the next 30 years.

The story of the changes taking place in clinical psychology has many subplots because the field has been shaped by several overlapping developments. Here, we focus on developments related to five main issues:

1. *Professional training*. What training does one need to become a clinical psychologist, and what are the options for obtaining it?

2. *Professional regulation*. What are the mechanisms for ensuring that a clinical psychologist possesses requisite skills and meets at least the minimum requirements to function professionally?

3. *Professional ethics*. What principles guide clinicians in determining the ethical *standards* for their profession? How is unethical behavior handled?

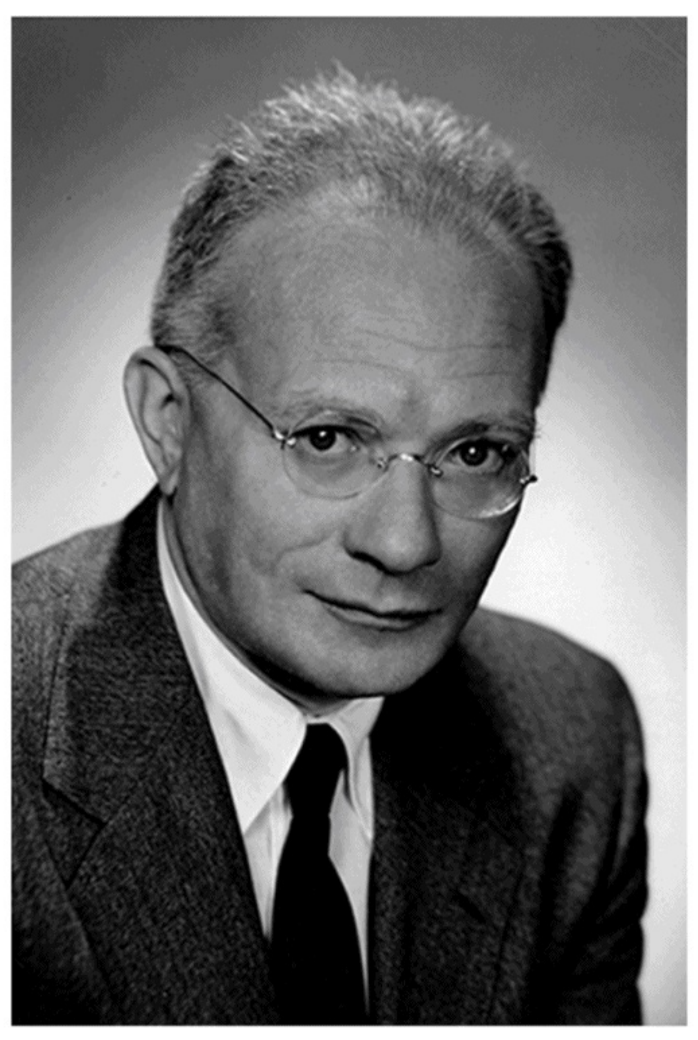
4. *Professional independence*. What is the relationship between clinical psychology and other mental health professions?

5. *Professional multicultural competence*. How has the field changed with regard to diversity and the need for multicultural competence?

Professional Training

Section Preview In this section, we discuss the historical and current forces that have affected professional training in clinical psychology. These include a number of national conferences on training, the development of the doctor of psychology (Psy.D.) degree, and the establishment of various training models. A recent internship crisis is also discussed.

As described in Chapter 2, the first four decades of the 20th century saw little progress in the creation of advanced training in clinical psychology. For clinicians of that period, experience was not only the best teacher, it was practically the only one. It was not until the late 1940s that clinical psychology found a unique opportunity to establish its identity, expand its functions, and elevate its status. During and after World War II, there was a dramatically increased need for mental health professionals (including clinical psychologists) who could work with combat veterans and their families, so when the Veterans Administration and the U.S. Public Health Service announced that they would provide support for the training of graduate students in clinical psychology, clinicians focused their attention on what that training should involve.



David Shakow (1901–1981)
The Shakow Report set an early standard for clinical psychology training and remains, with surprisingly few exceptions, a standard against which modern clinical programs can be evaluated.

(Source: Dipper Historic/Alamy Stock Photo.)

One of the most influential of these clinicians was Dr. David Shakow, chief psychologist at the Worchester State Hospital in Massachusetts, and leader of an APA Committee on Training in Clinical Psychology that was charged with formulating a recommended clinical training program. The committee prepared a report entitled “Recommended Graduate Training in

Clinical Psychology," which was accepted by the American Psychological Association in September 1947 and published that same year in the APA's main journal, the *American Psychologist* (American Psychological Association, 1947). Of the many recommendations in the Shakow report, the three most important were that:

1. A clinical psychologist should be trained first and foremost as a psychological scientist, not just as a clinician.

2. Clinical training should be as rigorous as the training for nonclinical areas of psychology.

3. Preparation of the clinical psychologist should be broad and directed toward assessment, research, and therapy.

The Shakow report suggested a year-by-year curriculum to achieve these goals in a 4-year time frame. Many of today's clinical training programs are based on that schedule, but it now usually takes about 6 years for students to complete all their training for a Ph.D. in clinical psychology, including the internship (Norcross & Sayette, 2018). The need for extra years arises because most programs require students to complete a master's thesis (usually in the second year), some require full proficiency in statistics and research methods, and many require courses in specialty areas such as human diversity, substance abuse, health psychology, clinical child psychology, sexual problems, and neuropsychological disorders.

The greatest impact of the Shakow report was to prescribe the special mix of scientific and professional preparation that has typified most clinical training programs ever since. This recipe for training—described as the *scientist–professional model*—was officially endorsed at the first major

training conference on clinical psychology, which was held in Boulder, Colorado, in 1949 (Raimy, 1950).

The Boulder Conference

The Boulder Conference on Training in Clinical Psychology was convened with the financial support of the Veterans Administration and the U.S. Public Health Service, which asked the APA to name the universities that offered satisfactory training programs, and to develop acceptable programs in universities that did not have them. Because the Boulder participants accepted the recommendations of the Shakow Report for a scientist–professional model of training, Shakow's plan became known as the *Boulder model***.**

Participants at the Boulder Conference further agreed that there should be a mechanism for monitoring, evaluating, and accrediting clinical training programs and internship facilities. As a result, APA formed an Education and Training Board and a Committee on Accreditation that was charged with these tasks. That committee (now called the Commission on Accreditation) published training standards that clinical training programs have to meet in order to be accredited. The 2009 edition of these standards was called *Guidelines and Principles for Accreditation of Programs in Professional Psychology* (American Psychological Association, 2009), and applied to general training in clinical, counseling, and school psychology. As of 2017, however, the APA Commission on Accreditation began using a new system, called *Standards of Accreditation for Health Service Psychology* (SoA; American Psychological Society, 2018f). The SoA does not list required courses and specific training experiences, but focuses instead on ensuring that accredited training programs are capable of graduating psychologists whose

competencies will enable them to provide high-quality health-care services (Belar, 2014).

Currently, clinical training sites are visited by an APA accreditation team about every 5 to 7 years, though the maximum interval can be 10 years. The results of accreditation site visits are published each year in the *American Psychologist* and can also be found online at the website of the APA Commission on Accreditation (www.apa.org/ed/accreditation/programs/clinical.aspx). As of 2018, there were 405 active APA-accredited doctoral programs, 244 (60%) of which were in clinical psychology, 76 (19%) in counseling psychology, 70 (17%) in school psychology, and 15 (4%) in combined programs (American Psychological Association, 2018g). There are many other doctoral training programs that operate without APA accreditation, either because the program has not requested a site visit or because approval has not been granted after a visit (see Chapter 16 for more information about the importance of APA accreditation).

The Boulder model remains the pivotal point for discussions of clinical psychology training today, but ever since its birth in 1949, some clinicians have not been happy with it. A number of alternative training models have been considered in several subsequent conferences, including the 1955 *Stanford Conference* (Strother, 1956), the 1958 *Miami Conference* (Roe et al., 1959), the 1965 *Chicago Conference*, and two especially important ones at Vail, Colorado in 1973 (Korman, 1976), and at Newark, Delaware in 2011 (Shoham et al., 2014).

The Vail Conference

With grant support from the National Institute of Mental Health (NIMH), the 1973 *Vail Conference* brought together representatives from a wide range of psychological specialties and training orientations, including graduate students and psychologists from various ethnic minority groups. Conference participants concluded that clinical psychological knowledge had advanced to a point that justified going beyond the Boulder model to create training programs with an emphasis on preparing students mainly for clinical practice. The conferees therefore officially recognized practice-oriented training as an acceptable model for departments of psychology that defined their mission as preparing graduate students to deliver clinical services. These "unambiguously professional" programs were to be given status equal to that of their more traditional scientist–professional counterparts. Thus began the new Doctor of Psychology degree, now known as the *Psy.D.* degree, which we describe later (Stricker, 2011).

One of the most controversial of the Vail recommendations was that, like Ph.D.s, people trained at the master's level should also be considered professional psychologists. The M.A. proposal was short-lived, as the APA voted that the title of *psychologist* should be reserved for those who have completed a doctoral training program. This policy remains in effect today, but it has come under intense attack as the number of M.A. psychology graduates continues to grow and as many states have allowed master's-level clinicians to practice independently. Indeed, as described in Chapter 1, master's-level clinical, counseling, and school psychology programs accept a higher percentage of applicants than doctoral-level programs do.

Furthermore, three times as many students graduate with master's degrees as with Ph.D.s (American Psychological Association, 2016a; Kohout & Wicherski, 2010).

The Salt Lake City Conference

The 6th National Conference on Graduate Education in Psychology was held in 1987, at the University of Utah in Salt Lake City. It was convened for several reasons, including the need to evaluate several changes that had taken place in the training of professional psychologists since the Vail conference. There was also a desire to reduce growing tensions between scientists and practitioners over numerous training and organizational issues. The participants passed 67 resolutions, the most important of which was that accredited clinical psychology training programs must expose their graduate students to a standard core of psychological knowledge, including research design and methods; statistics; ethics; assessment; history and systems of psychology; biological, social, and cognitive-affective bases of behavior; and individual differences (Bickman, 1987; see also a special issue of the *American Psychologist*, December 1987).

The Delaware Conference

The most recent training-related conference took place at the University of Delaware in October of 2011. It was convened in part because many clinical scientists felt that today's clinical students are not being sufficiently prepared to address four key areas of clinical science, namely: (a) basic mechanisms of psychopathology; (b) intervention development; (c) efficacy and effectiveness research; and (d) the science of dissemination and implementation (Shoham et al., 2014). As mentioned briefly in Chapter 1, the upshot of the conference has become known as the *Delaware Project*. Its goals are to generate state-of-the-science training resources and recommendations relevant to knowledge generation across all stages of intervention development, not just to define a single standard model of clinical training. In other words, unlike the results of most other training conferences, the Delaware Project is aspirational rather than prescriptive and regulatory (Onken et al., 2014). You can learn much more about the Delaware Project at its website (www.delawareproject.org).

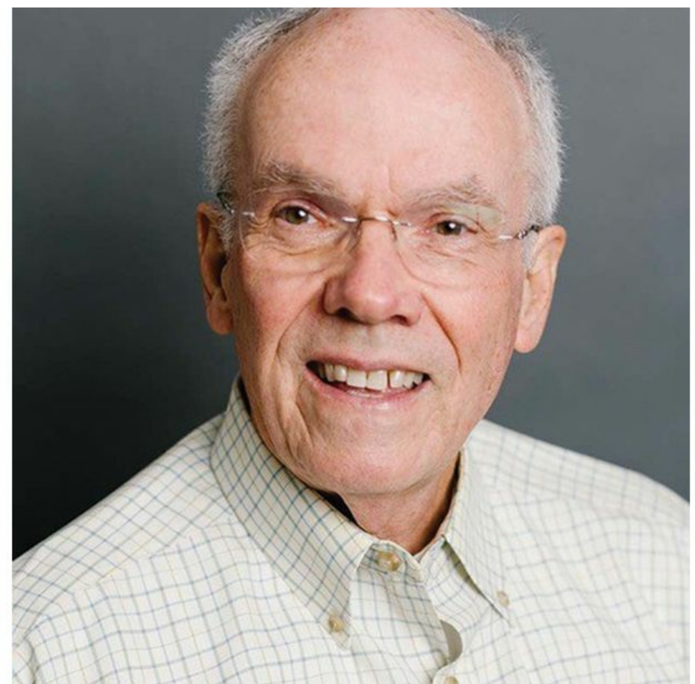
Clinical Psychology Training Today

What does training in clinical psychology look like after all these conferences, discussions, debates, and arguments among clinicians, educators, and students? There is no easy answer because training can vary, but we can provide a general summary.

First, the scientist–practitioner model has proven to be a tough competitor and is still reflected in more clinical psychology training programs than any other model (Klonoff, 2011). However, in light of conference recommendations, changes in APA accreditation guidelines, and the advent of accreditation offered through the Academy of Psychological Clinical Science (described below), many programs that favor the scientist–practitioner model are struggling to find the best way to train clinical psychologists so that their practical skills are well integrated with a solid foundation of scientific knowledge.

Partly in reaction to what he saw as the continued disconnect between science and practice, Richard McFall (1991) wrote a "Manifesto for a Science of Clinical Psychology," which highlighted the need for all practice to be research based. He argued that "scientific clinical psychology is the only legitimate and acceptable form of clinical psychology" (p. 76). Three years later, in 1994, McFall and other empirically oriented clinical psychologists formed the Academy of Psychological Clinical Science (APCS). Consistent with its empirical research focus, the Academy is housed within the Association for Psychological Science (APS) rather than the more practice-oriented American Psychological Association. The Academy, which is made up of graduate training programs committed to clinical science, was created

in response to concerns that recent developments in health-care reform and licensure and accreditation requirements threaten to erode the role of science and empirical research in the education of clinical psychologists.



Richard McFall

His “Manifesto for a Science of Clinical Psychology” led to the founding of the Academy of Psychological Clinical Science. As of 2020, Academy members included 66 doctoral programs and 12 internship sites; you can see the latest list at the APCS website.

(Source: With permission from Richard McFall.)

Academy-accredited programs are committed to training students in interventions and assessment techniques based on empirical research evidence like that summarized in Chapter 7. Many of the faculty in these programs, and in other research-oriented clinical programs, became increasingly concerned by what they saw as a lack of rigor in the APA

accreditation system's standards for what constitutes scientific clinical research. They were also concerned that the long list of requirements that students must fulfill for a program to maintain APA accreditation made it difficult for students to dedicate as much time to research as would be desirable. As a result, a subset of Academy member departments developed an accreditation system that was both more research-oriented and based more on educational outcomes rather than on meeting certain requirements. The result was the *Psychological Clinical Science Accreditation System* (PCSAS; Baker, McFall, & Shoham, 2009). The first clinical training program was accredited by PCSAS in 2009 and today there are 39, along with seven more that are being reviewed for accreditation. You can see the latest list at http://pcsas.org/.

Dr. Varda Shoham (1948–2014) was a champion of the clinical science model. She worked tirelessly to promote this model through service in the

Society for a Science of Clinical Psychology, the Academy of Psychological Clinical Science, and the Psychological Clinical Science Accreditation System.

(Source: Supplied with permission by Michael J. Rohrbaugh, PhD)

As of 2020, all of the programs accredited by PCSAS have also maintained their APA or CPA (Canadian Psychological Association) accreditation, but a number of programs have indicated that they may not seek to renew their APA accreditation when it comes time for a reaccreditation review. Whatever they decide, it is clear that member programs of the Academy, the programs accredited by the PCSAS system, and their faculty are playing critical roles in moving the field of clinical psychology toward a more scientific, evidence-based orientation (McFall, 2012).

Professional Schools and the Doctor of Psychology (Psy.D.) Degree

As suggested by the existence of two different accreditation systems, the last several decades have seen the creation of graduate programs with differing philosophies about how to train clinicians (Norcross, Kohout, & Wicherski, 2005). Some emphasize training in clinical science more than clinical practice, others take the opposite approach, and still others try to balance the two. As we mentioned in Chapter 2, proposals to emphasize practice over research in clinical psychology training appeared as early as 1917. However, it was 1951 before the first university-based professional school of psychology appeared in the United States, at Adelphi University. Then, in 1970, the first freestanding, non-university-based professional school of psychology was established as the California School of Professional Psychology (CSPP), with campuses in Los Angeles and San Francisco (Benjamin, 2005). Some practice-oriented programs are still housed in university psychology departments, but many more are to be found in freestanding professional schools of psychology.

At some freestanding schools, including the CSPP, students can study for a Ph.D., but most of them offer only the Psy.D. degree. The Psy.D. programs offered at most professional schools provide training that concentrates on the skills necessary for delivering a range of assessment, intervention, and consultation services. In most cases, a master's thesis is not required, nor is a research-oriented dissertation, although some kind of written, doctoral-level report is usually required. Psy.D. graduates are more likely than Ph.D. graduates to be employed in independent practice, managed care, and other health service settings (Norcross & Sayette, 2018).

The number of APA-accredited Psy.D. programs continues to grow. As of 2019, there were 93 of them (American Psychological Association, 2019b). This is far fewer than the 312 APA-accredited Ph.D. programs, but Psy.D. programs enroll far more students than do practice-oriented, research–practice, or research-oriented Ph.D. programs (Norcross, Ellis, & Sayette, 2010). Because of these larger enrollments, more students are graduating each year from Psy.D. programs than from Ph.D. programs (Sayette, Norcross, & Dimoff, 2011). One reason why Ph.D. programs tend to have fewer students is that, unlike Psy.D. programs, they tend to provide significant financial aid to most or all of those they admit (Norcross, Ellis, & Sayette, 2010). Another reason is that, compared to Ph.D. programs, Psy.D. programs tend to admit students with lower mean grade point averages (GPA) and Graduate Record Exam (GRE) scores (McFall, 2006; Templer, 2005).

There is a great deal of heterogeneity among Psy.D. training programs (Norcross et al., 2004), so it is difficult to make general statements about them. However, there are a number of troubling features associated with freestanding Psy.D. programs that are not as prevalent in university-based Psy.D. programs. For one thing, the higher acceptance rates and lower admission criteria at freestanding schools reflect their status as profit-making organizations, where, compared to universities with tighter fiscal controls, it is easier for mismanagement of funds to occur. Such mismanagement contributed to the 2019 collapse of Argosy University, one of the largest professional schools of psychology in the United States, many of whose programs had previously been offered through the American School of Professional Psychology.

Regardless of where Psy.D. programs are housed, their students are

slightly less likely—91.3 vs. 94.7%—than those of Ph.D. programs to be accepted into APA-accredited internship programs (Association of Psychology Postdoctoral and Internships Centers, 2019). Graduates of Psy.D. programs also tend to score lower than Ph.D. program graduates do on the Examination for Professional Practice in Psychology, a licensing exam described later in this chapter. Psy.D. graduates are also less likely to qualify for a specialty diploma from the American Board of Professional Psychology (also discussed later). In short, graduates of Psy.D. programs, especially those from programs housed in freestanding professional schools, are less likely overall to have the most distinguished career outcomes. So although there are some strong Psy.D. programs, given their variability, prospective students must be careful to select one whose graduates tend to experience good outcomes.

Clinical Psychology Training Models

As described in Chapter 1, three main models of clinical psychology training have emerged from conferences such as those held in Boulder and Vail (Klonoff, 2011):

- *The clinical scientist model*, which grew out of the Academy of Psychological Clinical Science approach and places heavy emphasis on scientific research. This model is most commonly followed in university settings.
- *The scientist–practitioner model*, which follows the Boulder conference recommendations and thus provides about equal emphasis on research and application to practice. This model is common in traditional university Ph.D. programs and in some professional schools.
- *The practitioner–scholar model*, which follows the Vail conference recommendations and thus stresses human-services delivery while placing proportionately less emphasis on scientific training. This model is most commonly seen in professional schools and many Psy.D. programs.

As you might expect, graduates of the practitioner–scholar model spend the least time doing clinical research, while graduates of clinical scientist programs spend the most time in that activity (Cherry, Messenger, & Jacoby, 2000; McFall, 2012). This pattern raises serious concerns among clinical scientists, who argue that the training provided by professional schools does not prepare graduates to properly evaluate the quality of the clinical research

they read. These critics point out that clinicians' ability to identify high-quality research designs opens the surest path to advancing their knowledge and promoting evidence-based clinical services (McFall et al., 2015).

For their part, advocates of professional school training have concerns about research-oriented training. They point out, for example, that only about half of the faculty who teach graduate students in Ph.D. training programs are engaged in clinical work themselves, even though most of them have a license to do so (Himelein & Putnam, 2001; Meyer, 2007). So practice-oriented clinicians worry that research-oriented programs provide their graduate students with too little appreciation of, or training in, the realities of clinical practice.

In short, advocates of the clinical scientist model want clinical psychology to develop as a research specialty focused on investigating the origins, assessment, and treatment of psychopathology. Those advocating the practitioner–scholar model want the field to develop as an applied profession devoted to clinical service. Ironically, most clinicians think that the scientist–practitioner model is a good idea, at least in theory (Grus, McCutcheon, & Berry, 2011). In practice, however, clinical psychologists often fail to integrate science and practice in their day-to-day work, partly because the incentive systems operating in their workplaces make such integration difficult.

For instance, university psychology departments seldom offer support or incentives for clinical faculty who wish to work with clients in a part-time private practice or in a nonprofit clinical setting (Overholser, 2007, 2010), and it is increasingly difficult for clinical psychologists without postdoctoral experience to become licensed while holding an academic position (DiLillo et al., 2006; Kaslow & Webb, 2011). Conversely, few independent practice

clinicians have the time or resources to conduct the kind of research that is published in scholarly journals (Overholser, 2010). These differing reward structures can reinforce attitudes and behaviors that further split the field into practitioners and researchers. So it seems that the Boulder model is a good idea that has been difficult to fully implement (Belar, 2000; Grus, McCutcheon, & Berry, 2011).

Evaluating Clinical Psychology Training

Philosophical differences aside, what do we know about the comparative clinical effectiveness of graduates from the various training models? Not much. Most of the research comparing different training models focuses on the time students or professionals spend in various activities, where they are employed, how much they publish, or how they view the training they received. There is scant information about whether different training models ultimately lead to different outcomes in treating clients.

This situation is unfortunate, because the ultimate goal of clinical psychology training is to produce scientists and practitioners whose work will reduce the burden of mental disorders (Levenson, 2017). We believe that clinical training programs should be evaluated not in terms of specific courses or requirements, but in light of whether they produce clinicians who are competent at performing the professional functions that their work demands. We think that in teaching these technical competencies, training programs should emphasize assessment and treatment methods that have been supported by empirical evidence; they should not offer training in methods or services that have not garnered such support. Indeed, to us, the key elements in training are teaching graduate students how to: (a) evaluate and choose assessment and treatment methods on the basis of high quality research evidence; and (b) directly evaluate the effectiveness of the treatment being provided to each client. Outcome monitoring at the individual client level is especially important when there is minimal applicable research evidence. We believe that if clinical training moves too far from its foundation in psychological science and teaches therapy techniques,

assessment methods, and other professional skills without regard for their empirical support, clinical psychologists will become narrowly specialized practitioners for whom research is of only passing interest. If that happens, clinical psychology will become a poorer science and, ultimately, a weaker profession.

The Internship Imbalance

No matter their location or training model, almost all graduate programs in clinical psychology require their students to complete a full-time, 1-year clinical internship. The overwhelming majority of APA-accredited programs require that this internship also be one that is APA-approved.

The coordinating entity for matching graduate students to internships in the United States and Canada is APPIC, the Association of Psychology Postdoctoral and Internships Centers. Graduate students submit applications for internships through APPIC's website, usually in November, and in early December applicants are invited for interviews which take place from mid-December to early February. In the second week of February, applicants submit a rank-ordered list of the internships they desire and training directors at the internship sites submit a rank-ordered list of the applicants they prefer. These rankings are processed by a computer that is programmed to match applicants to internship settings in a way that maximizes the desired outcome for both. The results are revealed on a national "match" day, usually in late February. A second round of computerized matching is conducted later to help nonmatched applicants find unfilled internship slots.

The internship requirement has been in place for decades, but an internship imbalance arose over the past decade as the numbers of graduate students in clinical psychology has grown and the number of internship slots shrank due to funding problems (Hatcher, 2011a, b; McCutcheon, 2011). For example, in 2012, there were 915 applicants who were not matched to any type of internship, and the problem was even worse for the APA/CPA-approved internship settings that are required by most APA/CPA-accredited

graduate programs. The match rate for internship applicants from those programs was only 53.3 percent in 2012. Because the internship application cycle occurs only once a year, failing to be matched is a serious impediment to nonmatched students' ability to complete their training.

Various task forces, advocacy groups, and scholarly discussions have addressed what had become the internship crisis (Grus, McCutcheon, & Berry, 2011). As a result, efforts are being made to obtain more federal funds for psychology training, develop more internship slots, decrease the number of students enrolled in graduate programs, and prepare students to be more competitive internship applicants. These efforts seem to have helped, because in 2019, only 3.1 and 6.3 percent of clinical psychology students from Ph.D. and Psy.D. programs, respectively, were not matched (see Match Statistics at appic.org). It will be crucial to keep an eye on these figures in the coming years to ensure that the matching situation continues to improve.

In Review Professional Training

Major Clinical Training Conferences	**Major Recommendations**
Boulder (1949)	Adopt Shakow Report: Training should be for a Ph.D. that emphasizes research and science as central to clinical training.
Vail (1973)	Practice-oriented training with less emphasis on research is acceptable (supported legitimacy of the Psy.D. degree).
Delaware (2011)	Training should focus on conducting clinical science as well as on dissemination and implementation of clinical science findings.
Clinical Training Models	**Essential Features**
Clinical scientist	Strong emphasis on scientific research; commonly found in university settings.
Scientist practitioner	Approximately equal emphasis on research and practice; commonly seen in traditional Ph.D. programs and in some professional schools.
Practitioner scholar	Strong emphasis on human-services delivery; places less emphasis on scientific training; very common in professional schools and many Psy.D. programs.
Test Yourself	

1. The _________training model is advocated for by the Academy of Psychological Clinical Science.

2. The _________model follows the training recommendations of the Vail conference.

3. The _________model follows the recommendations of the Boulder conference.

You can find the answers in the Answer Key at the end of the book.

Professional Regulation

Section Preview This section highlights the reasons for certification and licensure in clinical psychology and delineates the processes required to obtain both. ABPP certification is also described.

A major responsibility of any health-care or human-services profession is to establish standards of competence that members of the profession must meet before they are authorized to practice. The primary purpose of such **professional regulation** is to protect the public from unauthorized or incompetent practice of psychology by impostors, the untrained, or psychologists who are unable to function at a minimum level of effectiveness. Unlike in other areas of life, *caveat emptor* ("let the buyer beware") does not provide adequate protection, because the "buyers" seeking mental health services may not be sufficiently aware of who is qualified to offer those services and who is not. Accordingly, clinical psychology in the United States and Canada has developed an active system of professional regulation.

Professional regulation
In clinical psychology, establishing standards of competence that must be met in order to be authorized to practice.

Certification and Licensure

The most important type of regulations are state laws that establish requirements for the practice of psychology and/or restrict the use of the term *psychologist* to people with certain qualifications. This legislative regulation comes in two kinds of statutes: certification and licensure.

Certification laws restrict use of the title *psychologist* to people who have met requirements specified in the law. Certification protects only the title of psychologist; it does not regulate the practice of psychology. **Licensure** is a more restrictive type of statute. Licensing laws define the practice of psychology by specifying the services that a psychologist is authorized to offer to the public. The requirements for licensure are usually more comprehensive than for certification. To distinguish between certification and licensure, remember the following rule of thumb: Certification laws dictate who can be called a psychologist, while licensing laws dictate both the title and the services that psychologists may offer.

Certification

Professional regulation through laws that limit the title *psychologist* to people who have met certain requirements specified in the law.

Licensure

Professional regulation through laws that define the services that a psychologist is authorized to offer.

All 50 states, the District of Columbia, and all Canadian provinces have certification or licensure laws. In many U.S. states, certification and licensure laws are combined in a single statute. Licensing laws are administered by *state boards of psychology*, which are charged by state legislatures to regulate the practice of psychology. These state boards of psychology perform two major functions:

- determining the standards for admission to the profession and administering procedures for selecting and examining candidates, and
- regulating professional practice and conducting disciplinary proceedings involving alleged violators of professional standards.

The steps involved in becoming licensed differ somewhat from place to place, but there is enough uniformity across most U.S. states to offer a rough sketch of the process (see Table 15.1). Currently, the *Association of State and Provincial Psychology Boards* (ASPPB) coordinates the activities of the state boards of psychology and attempts to bring about uniformity in standards and procedures. ASPPB has developed a standardized, objective test for use by state boards in examining candidates for licensure. First established in 1964 and revised frequently since then, this **Examination for Professional Practice in Psychology (EPPP)** is sometimes called the *national exam* because all jurisdictions can use it as a part of their examination procedure. Though required for licensing, passing this test does not by itself guarantee

competence. There is no firm evidence that EPPP scores are valid for predicting the quality of a candidate's clinical work (Sharpless & Barber, 2009). In most states, a person must meet all other licensure requirements before being eligible to take the EPPP.

> **EPPP (Examination for Professional Practice in Psychology)**
> A standardized, objective test for use by state boards in evaluating candidates for licensure.

Table 15.1 So You Want to Be a Licensed Psychologist?

Imagine you have just completed a doctoral program in clinical psychology and you wish to become a licensed clinical psychologist. Here are the steps that are required in most states. First, you must ask the state board of psychology to review your credentials to determine your eligibility for examination. Their decision will be based on several criteria:

1. ***Administrative Requirements.*** You must have reached a certain age and must not have committed any felonies, engaged in treason, or libeled your state governor. These activities are judged to be indicative of poor moral character and may leave you plenty of time to fantasize about licensure while in prison.
2. ***Education.*** Most states require a doctoral degree in psychology from an accredited university, meaning one that has been approved by a recognized accrediting agency. However, many states require that you have graduated from an APA- or PCSAS-accredited training program. You will have to provide official graduate and undergraduate transcripts to show that you have met educational requirements. It is not unusual for state boards to request additional documentation to demonstrate that you have the

requisite coursework, including syllabi and reading lists.

3. *Experience.* This requirement usually amounts to multiple years of supervised professional experience in settings approved by the board. In most states, some of the experience must be postdoctoral; letters of reference will be required from your supervisor(s). If, after scrutinizing all of your credentials, the board finds that you are eligible for examination, you will be invited to take one or more examinations.

Most states use the EPPP national examination, which until 2020 had been a multiple-choice exam consisting of 225 questions covering general psychology, methodology, applications of psychology, and professional conduct and ethics. The ASPPB now uses an enhanced, two-part version. Part I focuses on content knowledge, whereas Part II focuses on professional skills. The test is available online throughout the year at various websites (see www.asppb.org, where you can also keep up with the latest news about the test). In some states, if you want to practice a specialty such as clinical, school, or industrial psychology, you will be required to take additional tests of your knowledge of content, ethics, laws, and regulations in these areas.

The fee for taking the EPPP is $600 per part, for a total of $1200. Fees for having a state board review your credentials range from $50 in Illinois to $733 in Florida; the average is between $200 and $300 (DiLillo et al., 2006; Matthews & Matthews, 2009).

The state board may also require that you take and pass an oral examination that covers any and all material relevant to psychology and clinical psychology.

If you pass all these tests—congratulations!!! Now you have the right to call yourself a psychologist, practice your specialty, and pay for rather expensive malpractice insurance. No really, congratulations!!

If you fail any part of the examination process, you will have a chance to retake that portion. Most boards feel that twice is enough, however; so if you fail again, it might be time to consider another career path.

These other requirements include having certain kinds of graduate training and clinical internship experiences. In a number of states, only graduates of APA-accredited doctoral programs may be licensed, which makes a student's choice about where to go for graduate training particularly important (see Chapter 16). Psychology doctoral graduates in most states must complete postdoctoral supervised activities in order to be eligible for licensure. These activities can include direct clinical practice, research, teaching, consulting, and the like, but in most states the work must consist of 1500 to 4000 hours under the close supervision of a licensed psychologist (Prinstein, 2013).

Postdoctoral positions can be APA-accredited ones, but many psychologists receive their postdoctoral training where they take their first job (Matthews & Matthews, 2009).

In most states, too, psychologists are required to keep their license or certification up to date by paying a periodic renewal fee and by documenting their involvement in *continuing education* (CE). The number of required continuing education hours varies across states; the range is 20 to 40 per 2-year licensing cycle (Neimeyer, Taylor, & Philip, 2010). Many participants report that CE activities gave them new knowledge and increased their effectiveness as practitioners (Neimeyer et al., 2019), but some observers wonder about how valid these reports are and whether state licensing board requirements focus too much on the number of CE hours and not enough on the quality of what's going on during those hours (Cox & Grus, 2019; Washburn et al., 2019).

Reciprocity of Licensure. Because licensing laws vary among states, there is not much *reciprocity* from one to another. This means that someone licensed as a psychologist in one state cannot automatically transfer that

licensure to another state. This situation greatly limits *professional mobility* for licensed psychologists, whether they are just starting their careers or simply wishing to move to another state later on (Matthews & Matthews, 2009). There are even bigger obstacles to retaining one's licensure in other countries (Hall & Lunt, 2005). There has been enough concern about the lack of reciprocity among states that, in 2010, the American Psychological Association updated its Model Act for State Licensure of Psychologists (Clay, 2010). Among other things, the revised model licensure act attempts to set consistent standards that would make it easier to move one's license from state to state. The Model Act suggests that one way of doing that would be for states to stop requiring all professional experience hours to be postdoctoral hours. Instead, states could allow licensure applicants to satisfy the state's required training hours either in their predoctoral program or through a combination of predoctoral and postdoctoral work (Schaffer, DeMers, & Rodolfa, 2011). The Model Licensing Act is intended to make licensure more manageable and more movable, but in order for it to be of maximum benefit to psychologists wishing to relocate, it will have to be adopted by many, if not all, states (Clay, 2010). To date only 17 states allow applicants to count pre-internship hours towards licensure.

The APA, the ASPPB, and the National Register of Health Service Providers in Psychology (known as the *National Register*) continue to work to increase licensure reciprocity, but it has proven to be a challenging task (Hall & Boucher, 2008). One potentially useful resource for psychology license applicants are "credential banks" that allow applicants to submit their credentials online and then apply for licensure in multiple states if they wish (Matthews & Matthews, 2009). Further, licensed psychologists who have at least 5 years of professional experience, who have no professional

disciplinary actions filed against them, and who meet certain other requirements can apply for a *Certificate of Professional Qualification in Psychology* through ASPPB. This certificate can be useful in seeking licensure in a state other than the one in which the person was originally licensed (Robinson & Habben, 2003). Similarly, certification through the National Register or achieving *diplomate* (pronounced "DIP-plo-mate") status through the American Board of Professional Psychology (ABPP; see next section) may give practicing psychologists more mobility across state lines (Hall & Boucher, 2008).

A surprisingly large number of graduate students and early career psychologists do not know very much about the licensing processes we have described. For example, one study of nearly 4000 doctoral psychology graduate students found that although 92% of them planned to apply for licensure, 60% of that group had not yet begun looking into licensure requirements (Hall, Wexelbaum, & Boucher, 2007). In addition, over 75% of those wishing to be licensed were unfamiliar with credentialing organizations such as ASPPB and the National Register (Hall, Wexelbaum, & Boucher, 2007). The same pattern holds true among early career psychologists who were actually seeking licensure! A study of over 1800 such individuals found that less than 10% reported being very familiar with ASPPB and the National Register (Hall & Boucher, 2008). Obviously, greater efforts are needed within the profession to familiarize graduate students and early career psychologists with the facts they need to know about obtaining licensure and improving their chances for professional mobility.

ABPP Certification

Licensed clinical psychologists can seek another type of professional recognition, namely certification by the American Board of Professional Psychology (ABPP). This national organization was founded in 1947 to certify the professional competence of psychologists and to grant them diplomas in one of the 16 specialty-specific areas in psychology listed in Table 15.2.

Table 15.2 Diplomas awarded by the American Board of Professional Psychology

Achieving diplomate status in one of the specialty areas listed here is a sought-after distinction among many professional psychologists.

Behavioral and cognitive	Geropsychology
Clinical	Group
Clinical child and adolescent	Organizational and business consulting
Clinical health	Police and public safety
Clinical neuropsychology	Psychoanalysis
Cognitive and behavioral	Rehabilitation
Counseling	School
Couple and family	
Forensic	

Although it carries no special legal authority, an ABPP diploma is considered more prestigious than licensure. That's because whereas licensure signifies a *minimal* level of competence (and is required before seeking a diploma), diplomate status is an endorsement of professional expertise, an indication that the person possesses a masterful knowledge of some specialty

field. Accordingly, requirements for the ABPP diploma are more rigorous than for licensure. Depending on the specialty area, multiple years of experience are a prerequisite to even take the ABPP examination, which is conducted by a group of diplomates who observe the candidate dealing directly with clinical situations (e.g., giving a test or interacting with a therapy client) and who conduct an oral examination that includes the following related topics: professional knowledge, assessment competence, intervention competence, interpersonal competence with clients, ethical and legal standards and behavior, commitment to the specialty and awareness of current issues, and competence in supervision and consultation (Kaslow, Graves, & Smith, 2012). More information about ABPP diplomate status can be found at www.abpp.org.

In Review Professional Regulation

Types of Regulation	Description
State certification	Restricts use of the title *psychologist* to people who have met requirements of a certification law.
State licensure	Defines practice of psychology; specifies the services psychologists are authorized to offer.

Regulation Agencies	Description
Association of State and Provincial Psychology Boards (ASPPB)	Coordinates activities of state boards of psychology with the aim of bringing about uniformity in standards and procedures.
State boards of psychology	Determine standards for licensure or certification and conduct disciplinary hearings in cases of alleged violation of standards.
American Board of Professional Psychology (ABPP)	A national organization that awards diplomas in specialty areas to particularly well-qualified professional psychologists.

Test Yourself

1. The latest version of the EPPP tests both ________ and ___________.

2. Professional mobility can be impaired by limits on ____________ created by differences in state licensing regulations.

3. In most states, licensed psychologists are required to participate in __________ activities every year in order to retain their licenses.

You can find the answers in the Answer Key at the end of the book.

Professional Ethics

Section Preview We have mentioned the APA Ethical Principles of Psychologists and Code of Conduct in several other chapters. Here we describe how this Ethics Code is organized, how its standards are implemented, and how ethical violations are reviewed and acted upon. We also discuss professional malpractice and malpractice litigation.

Ethical Standards of the American Psychological Association

The APA's *Ethical Principles of Psychologists and Code of Conduct*, or Ethics Code for short, consists of a Preamble, a set of General Principles, and a large number of specific Ethical Standards (American Psychological Association, 2010b, c, 2017). The Preamble and General Principles describe the highest ideals to which psychologists aspire, and provide guidance to psychologists who are evaluating what would be ethically desirable behavior in certain situations. The Preamble provides an overview of the ethics code:

> *Psychologists are committed to increasing scientific and professional knowledge of behavior and people's understanding of themselves and others and to the use of such knowledge to improve the condition of individuals, organizations, and society. Psychologists respect and protect civil and human rights and the central importance of freedom of inquiry and expression in research, teaching, and publication. They strive to help the public in developing informed judgments and choices concerning human behavior. In doing so, they perform many roles, such as researcher, educator, diagnostician, therapist, supervisor, consultant, administrator, social interventionist, and expert witness. This Ethics Code provides a common set of principles and standards upon which psychologists build their professional and scientific work.*
>
> (American Psychological Association, 2017a)

The five General Principles of the Code include:

- ***Principle A: Beneficence and Nonmaleficence.*** The essence of this principle is that psychologists should "do no harm."

- ***Principle B: Fidelity and Responsibility.*** This principle states that psychologists must be trustworthy and uphold the highest ethical standards in their professional relationships.
- ***Principle C: Integrity.*** This principle encourages psychologists to remain accurate, honest, and truthful in their professional work.
- ***Principle D: Justice.*** This principle focuses on the need to treat all individuals, but especially clients, fairly and justly.
- ***Principle E: Respect for People's Rights and Dignity.*** This principle highlights the need for psychologists to treat individuals with the utmost respect for their dignity and individual freedoms.

These General Principles set the tone for psychologists to maintain the highest ethical standards as described in the Code. Unlike the General Principles, the **APA Ethical Standards** are legally enforceable. They apply to all members of the APA and may be used by other organizations, such as state boards of psychology and the courts, to judge and sanction the behavior of a psychologist, whether or not the psychologist is an APA member. The ethical standards are organized under the following ten headings:

1. *Resolving Ethical Issues*. This section contains standards about how psychologists are to resolve ethical questions or complaints.

2. *Competence*. The standards in this section state that psychologists must be trained in their specific area of expertise and that they must continue to keep current in their field in order to maintain competence. This section also addresses the issue of when psychologists have personal problems or conflicts that limit their ability to practice in a competent manner.

3. *Human Relations*. These standards deal with such topics as preventing unfair discrimination, sexual or other harassment, multiple relationships, conflict of interest, providing informed consent, and avoiding termination of clinical services when it is not in the best interest of the client.

4. *Privacy and Confidentiality*. This section covers psychologists' obligations to protect their clients' rights to confidentiality and privacy.

5. *Advertising and Other Public Statements*. These standards control the way psychologists publicize their services and how their professional credentials are presented.

6. *Record Keeping and Fees*. This section provides guidance on documenting professional work, maintaining and disposing of confidential records, setting fees and other financial arrangements, and making and receiving referrals.

7. *Education and Training*. This section contains several ethical standards that control psychologists' conduct as they teach and supervise students.

8. *Research and Publication*. Standards that control psychologists' research activities are included in this section. They address topics such as receiving approval from an Institutional Review Board before conducting research, obtaining voluntary informed consent from human research participants, debriefing participants, providing publication credit for coauthors, sharing research data, and conducting reviews of scholarly work.

9. *Assessment*. This section lists rules pertaining to the use and interpretation of tests.

10. *Therapy*. Here, you will find rules about the structuring, conduct, and termination of therapy. Specific standards prohibit psychologists from having

sexual intimacies with current clients, or the relatives and significant others of current clients and from accepting as clients anyone with whom they have had previous sexual intimacies. Psychologists should also not have sexual intimacies with former therapy clients for at least 2 years after the termination of therapy, and even then only if the psychologist can demonstrate that no exploitation of the client has occurred.

APA Ethical Standards
Legally enforceable statements about what constitutes ethical and unethical behavior by psychologists in ten specific domains.

Implementation of Ethical Standards

Most psychologists take great pains to deal with complex and ethically ambiguous situations in accordance with the highest standards of professional conduct. But because many situations involve moral and cultural questions and do not match exactly the terminology used in the APA Ethics Code, there is often no single, clearly best course of action, no obviously right answer.

Consider Table 15.3, for example, which describes situations in which a therapist is in both a professional and a nonprofessional role with a client. Multiple relationships are considered unethical because they can harm the therapeutic relationship, create a conflict of interest, and ultimately harm the client. Do you think that is true in these cases?

Table 15.3 Three Examples of Potentially Unethical Behavior

Try this Take a minute and jot down some reasons why, or why not, the psychologist in each of the following cases might be guilty of unethical behavior.

Case 1. A therapist has been seeing a 45-year-old man for over a year for problems related to stress and anxiety. The client recently lost his job as an office administrator because the company went bankrupt, and he is looking for work. At the same time, the therapist is in need of an office assistant and records clerk, and she has had a hard time finding someone who meets her high standards. She knows that the client received rave reviews as an office assistant. She hires him to be her records clerk and continues to see him professionally.

Case 2. A therapist is treating a 38-year-old woman who has endured the painful breakup of a long-term relationship. The client mentions that she

loves dogs and that she finds great comfort in their company. The therapist happens to be an avid dog lover as well, and she raises and breeds border collies as a hobby. The therapist mentions that she has a new litter of puppies that are ready for new homes, and the client purchases one of them from the therapist.

Case 3. A cognitive behavior therapist is the only one in his small town who specializes in treating clients with anxiety disorders. A 63-year-old man calls this therapist for help with severe agoraphobia, but he has a limited income and no insurance, so he can afford to pay for only one session. During that session, the therapist learns that the client is an expert carpenter. The therapist offers to treat the client in exchange for carpentry services. The client accepts the offer and builds a set of bookshelves in the den of the therapist's home. (Adapted from Bersoff, 2008.)

How do psychologists manage such ethical problems? They begin by always remaining aware of acceptable and unacceptable practices within their area of professional activity. Other steps to minimizing the risk of unethical behavior include establishing proper informed consent procedures, release of information forms, and case documentation systems (Knapp, Bennett, & VandeCreek, 2012). Professionals can also refer to numerous handbooks and casebooks to gain a broader perspective on how other professionals have handled cases similar to the one at hand (e.g. Barnett & Johnson, 2008; Campbell et al., 2010; Knapp, 2012a, b, 2013; Nagy, 2010; Pope & Vasquez, 2016). Consultation with colleagues and professional organizations is also permitted as long as confidentiality can be maintained (or a release of information obtained from clients). Finally, many malpractice insurance companies provide consultation to clinician–policyholders who are seeking clarification on ethical and legal issues. Although taking these steps does not

render psychologists immune from malpractice suits or other legal actions, they do reflect a conscientious effort to do the right thing, and documentation of those efforts is likely to be looked upon favorably by professional organizations and courts.

Dealing with Ethical Violations

When, as fallible human beings, psychologists behave in an ethically questionable manner, they are subject to censure by local, state, and national organizations whose task it is to deal with violations of ethical practice. Clients or other individuals who believe that a psychologist has been involved in wrongdoing can file a formal complaint with the APA and/or the state psychology board. Fortunately, the number of such complaints against clinical psychologists is relatively small, but may allege multiple reasons; the vast majority of APA's nearly 120,000 members never have a formal complaint filed against them (Nagy, 2010). In 2017, only one complaint was deemed serious enough for the APA Ethics committee to pass it on to the APA Board of Directors for review. In 2018, the Ethics Committee conducted preliminary investigations of only 11 cases, none of which led to further action (Childress-Beatty, personal email communication, 2019).

Formal complaints against psychologists can be made by anybody, including clients and colleagues. The nature of the complaints vary, but as shown in Table 15.4, they typically involve allegations of unprofessional or negligent practice, sexual misconduct, dual relationships with clients, being convicted of a crime, improper record keeping, breach of confidentiality, and fraud—especially as related to inappropriate insurance billing (Knapp, Bennett, & VandeCreek, 2012; Pope & Vasquez, 2016).

Table 15.4 Top 10 Reasons for Disciplinary Actions Against Psychologists
The cases summarized here represent complaints filed against psychologists from 1974 to 2019 that resulted in disciplinary actions (multiple reasons in each case).

Reason for Disciplinary Action	Number Disciplined
Unprofessional conduct	1,040
Sexual misconduct	997
Negligence	736
Nonsexual dual relationship	649
Conviction of crime	565
Failure to maintain adequate or accurate records	441
Failure to comply with continuing education or competency requirements	398
Incompetence	368
Improper or inadequate supervision or delegation	315
Substandard or inadequate care	293
Other (the combined total of the 76 remaining reasons)	4,625

Source: ASPPB Disciplinary Data System, https://www.asppb.net/page/DiscStats

When a claim of unethical behavior by an APA member is judged by a state or national disciplinary committee to be true, some form of punishment will be imposed. The most severe APA sanction is to dismiss the offender from the association and to inform the membership of this action. Unethical conduct can also result in the state psychology board suspending or

permanently rescinding the offender’s professional license. Less severe consequences can include censure or censure with probation. As we describe later, clients or others can also seek legal and financial sanctions by filing lawsuits under a state’s professional malpractice laws.

Other Ethical Standards

The APA *Ethical Principles of Psychologists and Code of Conduct* is not the only one that applies to the activities of psychologists. Clinical psychologists in particular are responsible for knowing about these other standards. As we have mentioned in other chapters, clinicians must follow numerous general and specialty guidelines when conducting research, performing assessments and psychotherapy, and working with particular categories of clients. Examples include *Guidelines for Psychological Practice with Lesbian, Gay, and Bisexual Clients* (American Psychological Association, 2012a), *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People* (American Psychological Association, 2015a), *Guidelines for Assessment of and Intervention with Persons with Disabilities* (American Psychological Association, 2012b), *Guidelines for Psychological Practice with Girls and Women* (American Psychological Association, 2007b), and *Guidelines for Psychological Practice in Health-Care Delivery Systems* (American Psychological Association, 2013c).

Therapists, especially those working in medical settings or who bill insurance companies for their services, must follow additional rules and regulations. The *Health Insurance Portability and Accountability Act* (HIPAA) was established by the Department of Health and Human Services in order to protect the confidentiality of information about clients and to deal with other issues regarding insurance reimbursement (Nagy, 2011). Therapists who bill insurance companies also must register for a National Provider Identifier, which is another component of the HIPAA regulations (Munsey, 2007).

Regulation Through State Laws

The APA's ethical principles are usually consistent with state laws, but not always, so it is usually best for the psychologist to follow the more stringent of the two (American Psychological Association, 2010b). For example, whereas the APA ethical standards allow consensual sexual contact between therapists and their former clients 2 years after termination of the therapeutic relationship (as long as no harm can be reasonably expected to be done to the client as a result), many states forbid any sexual contact between therapists and their former clients, ever. Psychologists who live in a state that forbids such contact in perpetuity would be wise to follow the state law rather than to presume that the less stringent APA ethical code would protect them from criminal prosecution (Pope & Vasquez, 2011).

Duty to Warn. In addition to prohibiting certain conduct, some state laws require clinical psychologists to do certain things, even if—under special circumstances—it means violating normal ethical standards. For example, therapists normally keep clients' information strictly confidential, but what if clients reveal that they plan to harm someone? This was the question raised in the case of *Tarasoff vs. Regents of the University of California* (reviewed in Nagy, 2010), and the answer has turned out to be yes, at least in some states. Here are the facts of the case:

> *In 1969, Prosenjit Poddar, a student at the University of California–Berkeley, sought therapy through the student mental health services center. During a therapy session, Mr. Poddar told his psychotherapist, Dr. Lawrence Moore, that he intended to kill a young woman, Tatiana Tarasoff, who had apparently rejected his attempts to*

have a romantic relationship. The therapist informed his superior, Dr. Harvey Powelson, of this threat. The campus police were called and were also asked, in writing, to confine the client. They did so briefly, but then released him after concluding that he was rational, and they believed his promise that he would stay away from the Tarasoff's home. He did not do so. After terminating his relationship with his therapist, Mr. Poddar killed Ms. Tarasoff. He was later convicted of murder. No one had warned the woman or her parents of the threat. In fact, Dr. Powelson had asked the police to return Dr. Moore's letter and ordered that all copies of the letter and Dr. Moore's therapy notes be destroyed.

Ms. Tarasoff's parents sued the University of California–Berkeley, the psychologists involved in the case, and the campus police to recover damages for the murder of their daughter. Ultimately, the Supreme Court of California found in favor of the parents. Through this ruling, Ms. Tarasoff's parents helped to change mental health laws throughout the United States.

(Ewing & McCann, 2006)

In reaching its decision, the court weighed the importance of confidentiality in therapy relationships against society's interest in protecting itself from dangerous people. The balance was struck in favor of society's protection. As stated in the Court's judgment, "The protective privilege ends where the public peril begins."

The *Tarasoff* decision created a **duty to warn** the potential victims about clients whom a therapist believes, or should believe, are dangerous. The warning is mandatory in 27 states and Puerto Rico, whereas in 17 other states and the District of Columbia, warnings are permitted but not required. In a few states, duty to warn laws either do not exist or vary by profession

(Adi & Mathbout, 2018; Soulier, Maislen, & Beck, 2010). The rules continue to change, though, such that psychologists who fail to stay up to date about the laws regulating psychology in their state may not fully understand the conditions under which they might be held liable for not warning people who might be the target of a dangerous act by their client. Even in California, where the duty to warn originated, there is now only a duty to act to *protect* (Weinstock et al., 2014). So, a therapist can still warn the police and the target of a client's threat, but if doing so is judged to make the client even more dangerous, the therapist can take alternative protective actions. If, as happens now and then, the potential target may be the client's therapist, or former therapist, making the ethical issues especially complex and difficult (Erickson Cornish et al., 2019). Regardless of the details, therapists face a chilling dilemma in such cases because, as we mention in Chapter 3, it is exceedingly difficult to be sure when a client's threats are genuine and when they are harmless.

Duty to warn
A therapist's obligation or option to notify potential victims about potentially dangerous clients.

Regulation Through Malpractice Litigation

The conduct of clinical psychologists can also be regulated through civil lawsuits brought by clients who allege they have been harmed by the malpractice of those professionals. If a jury agrees with the client's claim, the clinician may be ordered to pay the client monetary damages to compensate for the harm. Four elements must be established in order to prove a claim of professional malpractice, namely that:

1. A special professional relationship (i.e., service in exchange for a fee) existed between the client/plaintiff and the clinician/defendant.

2. The clinician was negligent in treating the client. Negligence involves a violation of the standard of care, defined as the treatment that a reasonable practitioner facing circumstances similar to those of the plaintiff's case would be expected to give.

3. The client suffered harm.

4. The clinician's negligence caused the harm suffered by the client.

Fewer than 2% of clinicians will ever be sued for malpractice during their professional careers, a figure that has remained relatively stable for many years and is much lower than for medical specialists in obstetrics, emergency medicine, surgery, or radiology (Knapp, Bennett, & VandeCreek, 2012). At one time, the most common allegation in successful malpractice lawsuits was that the psychologist failed to prevent a client's suicide (Scott & Resnick, 2006), but that has now changed. Today, successful malpractice lawsuits are most likely to allege that the psychologist provided ineffective treatment, failed to consult with other psychologists to better serve their clients, or did

not refer clients to other therapists when they were not able to provide effective services (Pope & Vasquez, 2011; see Table 15.5).

Table 15.5 Most Common Sources of Professional Liability Claims Against Psychologists

The fact that most malpractice lawsuits involve claims of ineffective treatment underscores the need for therapists to be educated about and competent at providing the types of evidence-based practices discussed in Chapters 7 and 9.

Source of Alleged Malpractice	Percent of Cases
Ineffective treatment/failure to consult/failure to refer	29
Failure to diagnose/improper diagnosis	16
Custody dispute	10
Sexual intimacy/sexual harassment and/or sexual misconduct	9
Breach of confidentiality	8
Suicide	4
Supervisory issues, conflict of interest or improper multiple relationships	3
Libel/slander, conflicts in reporting sexual abuse, licensing dispute	2
Abandonment, premises liability, repressed memory, failure to monitor, countersuits resulting from fee disputes, client harmed others including homicide, business disputes, miscellaneous	1% each

liability claims, discrimination/harassment

Source: Adapted from Pope, K. S., & Vasquez, M. J. T. (2011). *Ethics in psychotherapy and counseling: A practical guide* (4th ed.). Hoboken, NJ: Wiley.

Some of the largest damage awards have come in a few instances in which therapists were accused of influencing clients to falsely recall supposedly *repressed memories* of physical or sexual abuse in childhood. Here is a famous case example:

> Gary Ramona—once a highly paid executive in the California wine industry—sued family counselor Marche Isabella and psychiatrist Richard Rose for planting false memories of trauma in his 19-year-old daughter, Holly, when she was their patient. Ramona claimed that the therapists told Holly that her bulimia and depression were caused by having been repeatedly raped by him when she was a child. They also told her that the memory of this molestation was so traumatic that she had repressed it for years. According to Ramona, Dr. Rose then gave Holly sodium amytal (a so-called truth serum) to confirm her "recovered memory." Finally, Isabella was said to have told Holly's mother that up to 80% of all bulimics had been sexually abused (a statement for which there is no scientific support).
>
> At the trial, the therapists claimed that Holly suffered flashbacks of what seemed to be real sexual abuse. She also became increasingly depressed and bulimic after reporting these frightening images. Holly's mother, Stephanie, who divorced her husband after Holly's

allegations came to light, testified that she suspected her husband had abused Holly and listed several pieces of supposedly corroborating evidence. Gary Ramona denied ever sexually abusing his daughter.

Dr. Elizabeth Loftus, a cognitive psychologist and leading critic of aggressive memory therapy, testified that therapists often either suggest the idea of trauma to their clients or are too uncritical in accepting the validity of trauma reports that occur spontaneously. It appeared that Holly's memory had been so distorted by her therapists that she no longer knew what the truth was.

The jury found that Holly's therapists had planted false memories in her and, in May 1994, awarded Gary Ramona $500,000. Since then, several other "false memory" cases have been successfully filed against therapists, in Wisconsin, Pennsylvania, Minnesota, and Illinois resulting in multimillion dollar judgments against therapists who had "found" their patients' lost memories (False Memory Syndrome Foundation, 2016; Heller, 2011; Loftus, 1998).

The best way for clinical psychologists and other mental health professionals to decrease their risk of being named in a malpractice lawsuit is to act with the highest level of professional integrity and avoid violating any ethical standards or laws governing mental health treatment (Knapp 2012a, 2012b). This is exactly what the vast majority of clinicians do.

In Review Professional Ethics

Sources of Ethical Standards or Regulations	**Content or Role**
APA Ethics Code	A preamble, five general principles, and ten sets of ethical standards.
APA Ethics Committee (national)	Considers cases in which violation of standards is alleged; decides on punishment if warranted.
State psychology boards	Consider cases in which violation of standards is alleged; decides on punishment if warranted.
APA general and specialty guidelines	Provide guidance for conducting research, performing assessments and psychotherapy, and working with particular categories of clients.
Health Insurance Portability and Accountability Act (HIPAA)	Sets rules and regulations for clinicians in medical settings or who bill insurance companies.
State malpractice laws	Establish rules by which psychologists accused of professional misconduct are judged in civil damages cases.
Test Yourself	

1. The _________ of APA's Ethical Principles of Psychologists and Code of Conduct are legally enforceable.

2. The deciding whether it is ethical to reveal a client's threat against a third party is complicated by the difficulty of _____________________.

3. Clinicians may consult with other professionals about the ethics of particular cases as long as they can protect their client's ___________.

You can find the answers in the Answer Key at the end of the book.

Professional Independence

Section Preview In this section, we tell the story of how clinical psychologists gained the right to practice psychotherapy independently and the right to receive insurance coverage for mental health services that are comparable to that given for medical services. The story includes the impact of changes in the economics of mental health service delivery and the various ways in which psychologists can earn a living. We conclude the section by describing the controversy over clinicians' right to prescribe medication.

As we mentioned in Chapter 1 and elsewhere, clinical psychologists often consult and collaborate with many other professionals. They work closely with educators, attorneys, religious leaders, social workers, nurses, physicians, and psychologists in other subfields. For the most part, psychology's interprofessional relationships are healthy, profitable, and characterized by goodwill. The most obvious sign of this harmony is the frequency of referrals made across groups.

Unfortunately, though, interprofessional relationships are not always so cordial. As described in Chapter 2, clinical psychology's most persistent interprofessional problem has been its wary, often stormy, relationship with the medical profession. Early disputes revolved around the role of psychologists as diagnosticians and treatment providers. More recently, the squabbles have concentrated on psychologists' eligibility for reimbursement under prepaid mental health plans and on efforts by some psychologists to gain the right to prescribe medication for their clients. Although these

controversies are related, we examine them in separate sections so as to clarify the development of each.

The Economics of Mental Health Care

Having won battles over licensure by the 1950s, and recognition of psychology as an independent profession in the 1970s and 1980s, clinicians turned to struggles involving the economic aspects of mental health care that existed back then. The initial focus of these struggles was whether psychologists should be eligible for insurance reimbursement for their services. Psychologists began lobbying state legislatures to pass *freedom-of-choice* laws, which mandate that services rendered by qualified mental health professionals licensed to practice in a given state shall be reimbursed by insurance plans covering such services regardless of whether the provider is a physician or a psychologist. By 1983, 40 states covering 90% of the U.S. population had passed freedom-of-choice legislation so that licensed psychologists were reimbursable providers of mental health services (Lambert, 1985).

Additional legislation at the federal level promoted recognition of psychologists as independent clinicians. The Rehabilitation Act of 1973 (PL 93-112) provided *parity* (i.e., equal coverage) for both psychologists and physicians in assessment and treatment services. In 1996, another federal law prevented insurance companies from providing lesser coverage for mental health as opposed to physical health services (Munsey, 2007). Clinical psychologists saw this law as a step in the right direction, but despite its name —the Mental Health Parity Act—there were still a number of limits to parity. It took 12 more years of discussions by policy makers, health-care administrators, psychologists, and other mental health professionals, before Congress passed the more comprehensive *Paul Wellstone and Pete Domenici*

Mental Health Parity and Addiction Equity Act. Because its goal is similar to that of the earlier law, this act is also commonly known as the Mental Health Parity Act. It took effect in 2010 (McConnell et al., 2012) and requires insurance companies to provide the same coverage for mental health disorders as they do for physical illnesses (Fritz & Kennedy, 2012). As a result, psychologists and other mental health service providers finally gained professional independence through equality in reimbursement for their work.

Parity for mental health services applies to all insurance companies and third-party payers, including those that offer *managed-care programs* (Gasquoine, 2010). These programs were developed as a means of allocating health services to a group of people in order to provide the most appropriate care while still containing the overall cost of service. Organizations that offer these plans typically provide specific packages of health-care services to subscribers for a fixed, prepaid price. The Mental Health Parity Act applies to all these programs, but it does not allow payment for unlimited mental health services, or services offered by just any licensed professional. So insurance companies and managed-care systems have established *insurance panels*, which are lists of professionals who have been approved to provide services for reimbursement (Goodheart, 2010). In addition, as with medical procedures, mental health services still require *utilization reviews* for both privately and publicly funded systems (Clay, 2011b). Thus, like medical doctors, most psychotherapists are bound by certain procedural guidelines (e.g., only a certain number of therapy sessions are preapproved for the cognitive behavioral treatment of depression) and may have to request preapproval before delivering some services. Often the approval for these services is based on their effectiveness, so as mentioned in Chapter 7,

utilization reviews constitute yet another reason that so many mental service health providers are focused on learning and using evidence-based practices.

Independent Practice

As discussed in Chapter 1, the financial rewards available to independent service providers in clinical psychology can be substantial. In 2015, the median annual salary for all doctoral-level clinical psychologists was $80,000, but was $85,000 for those in direct service jobs, and $120,000 for those in private practice (American Psychological Association, 2017b). As also noted in Chapter 1, the job market for clinical psychologists is expected to grow at faster-than-average rates, by about 14% from 2016–2022 (Bureau of Labor Statistics, 2018).

There are three main models for independent practice (Walfish & Barnett, 2009):

- Solo practice—The clinician owns the entire practice and is responsible for everything, including renting and decorating office space, purchasing assessment instruments, advertising, billing, and the like;
- Group practice—Two or more clinicians join forces and offer services together, usually sharing the costs of the office, office staff, equipment, and the like. Large group practices often hire associates, who either work for a fixed salary or who receive a percentage of the income they generate from their clients;
- Mixed-model practice—Two or more clinicians work together, as in a group practice, but they are legally and financially independent. For example, one clinician may simply rent space in the offices of another clinician.

In deciding which of these models of independent practice is best, clinicians must consider where their strengths and passions lie. Do they prefer to conduct assessments with young children, provide preventive interventions for at-risk youth, help couples work through separation and divorce, deal with adult eating disorders, help older adults with end-of-life issues, or what? Which practice model will best allow the pursuit of these interests? Clinicians must also remember that independent practices are small businesses, so in addition to considering the things they are good at and what they enjoy doing, psychologists must also consider whether there is a market for their services and if so, how to succeed in that market (Walfish & Barnett, 2009).

Reimbursement rates for clinical services vary widely—depending on whether the fees are coming from public health-care programs (such as Medicare or Medicaid) or from private insurance companies and managed-care programs (such as Blue Cross/Blue Shield or Humana). These rates also depend on geographic region (Gasquoine, 2010), so psychologists must consider the financial feasibility of opening a practice in their area of specialty and in their location.

Prescription Privileges

Though some aspects of medical and psychological practices have become more integrated, clinical psychologists and the medical profession remain at odds over the **prescription privileges movement**. This movement would allow specially trained clinical psychologists to prescribe psychotropic medication as well as offer psychotherapy.

> **Prescription privileges movement**
> Efforts to allow specially trained clinical psychologists to prescribe psychotropic medication for their clients.

Advocates of prescriptive authority point to several reasons that it should be granted. For one thing, surveys indicate that 98% of psychologists have referred a client to a psychiatrist or physician for psychotropic medication; 75% of them make such referrals on a monthly basis; and approximately one out of three clients of psychologists is taking psychotropic medication (Meyers, 2006). Thus, medication already is a frequent aspect of many clinical psychologists' practice. Further, many psychologists are concerned about clients' inability to gain access to psychiatrists and qualified primary care physicians. Allowing psychologists to prescribe medication, they say, will increase continuity of care and the quality of services available to clients from ethnic or racial minority backgrounds, those of low

socioeconomic status, and those living in rural or geographically isolated areas (Linda & McGrath, 2017).

In 1996, the APA Council of Representatives voted to support clinical psychologists' efforts to seek prescriptive authority. An APA Ad Hoc Task Force on Psychopharmacology suggested that most of the training necessary for obtaining prescription privileges could be conducted at the postdoctoral level. The Council also recommended model legislation to be introduced in states where psychologists are seeking prescriptive authority, as well as a model postdoctoral curriculum (covering neurosciences, pharmacology, physiology, physical and laboratory assessments, and clinical pharmacotherapeutics) to be used in training prescribers (McGrath, 2010).

The medical profession is not the only faction opposed to prescription privileges for clinical psychologists; it is a controversial proposal within psychology, too. Although many psychologists support prescription privileges for properly trained clinicians (McGrath & Sammons, 2011), others are worried that existing training for this activity is far less extensive than it is in other health professions and thus might be inadequate to assure client safety (see Figure 15.1). In fact, recent proposals for training psychologists to prescribe have dropped the prerequisite coursework in the biological and physical sciences that had been identified as necessary by the APA's Ad Hoc Task Force (Robiner, Tumlin, & Tompkins, 2013). Some of those who are alarmed by such changes argue that psychologists who want to prescribe medication should complete formal training as physicians or other medical professionals.

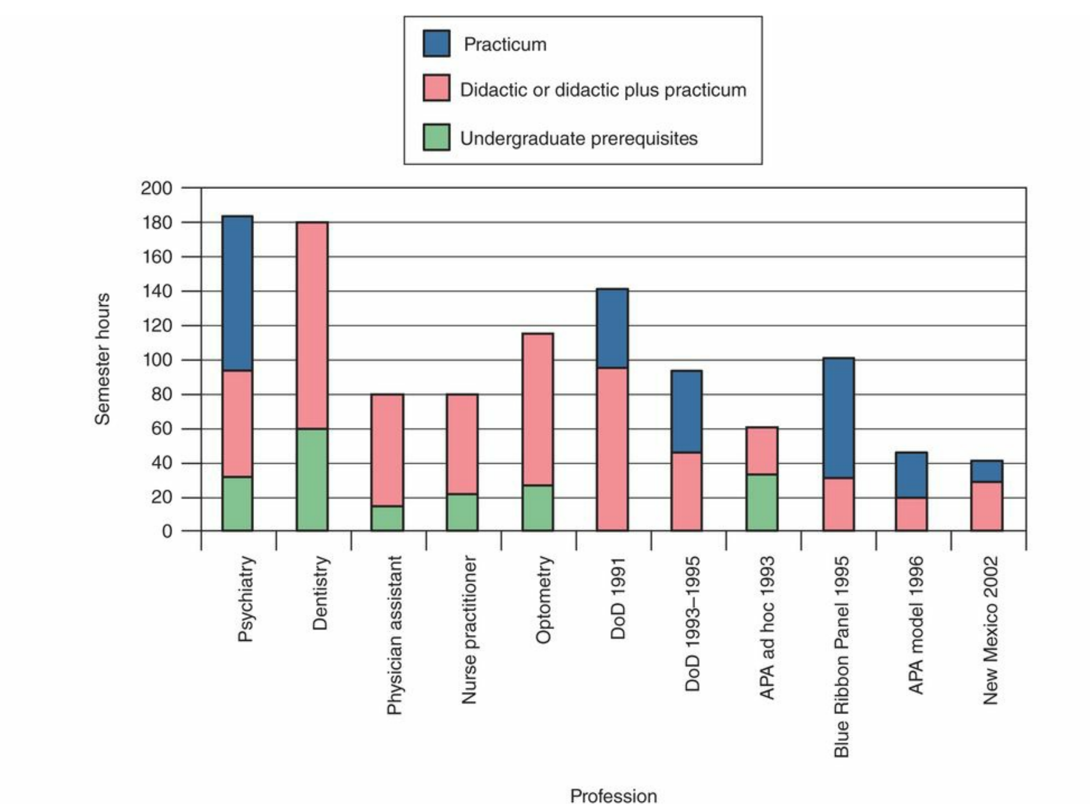


Figure 15.1 Typical Semester-Hour Medical Training by Professions with Prescriptive Authority Compared to Proposed Training of Psychologists to Prescribe

Opponents of prescription privileges for clinical psychologists say that these psychologists will not have adequate training in the medical and physical sciences and could thus become a health hazard to clients (see McGrath, 2010).

(Source: Heiby, E. M., DeLeon, P. H., & Anderson, T. (2004). A debate on prescription privileges for psychologists. *Professional Psychology: Research and Practice*, *35*(4), 336–344.)

Others are concerned that prescription privileges would lead to an increasingly intense focus on the medical and biomedical aspects of behavior, behavior disorder, and treatment, with a consequent loss of clinical psychology’s traditional focus on important psychosocial, environmental,

cognitive, and behavioral factors that help to explain and treat disorders (Levine & Schmelkin, 2006). They remind us that “if you give someone a hammer, then everything looks like a nail,” meaning that if psychologists have prescriptive authority, every client’s problems might seem to require drug treatment rather than psychotherapy.

Despite strong arguments from inside and outside psychology that prescription privileges for clinicians could be dangerous to clients and detrimental to the profession (Tumlin & Klepac, 2014), as of 2020, state legislatures in Iowa, Idaho, Illinois, New Mexico, and Louisiana have passed laws allowing specially trained clinical psychologists to prescribe. Prescriptive authority is also allowed for psychologists in the territory of Guam, in the military, and in the Indian Health Service (American Psychological Association, 2011b). Over half of the other states have considered and rejected prescription privileges bills. Would clinical psychologists in these other states apply for prescriptive authority if it were available? The answer is unclear. One survey suggested that clinical interns and training directors who favor prescriptive authority would seek prescriptive authority (Fagan et al., 2004), but even when it is legal, psychologists may not find it to be attractive. One study found, for example, that only 5% of nurse psychologists chose to seek prescriptive authority and were actually prescribing (Wiggins & Wedding, 2004). And in New Mexico and Louisiana, where psychologists are eligible for prescriptive authority, very few psychologists are seeking the training necessary to attain it (Munsey, 2008; Tompkins & Johnson, 2016). This apparent lack of interest in pursuing prescription privileges greatly undercuts the argument that prescriptive authority will lead to improved access and enhanced patient care. So whether or not prescriptive privileges for psychologists are eventually

granted throughout the United States, most professionals agree that those psychologists should proceed cautiously as they consider this important option in their training and practice.

In Review Professional Independence

Laws Supporting Independent Practice of Psychology	Provisions
State freedom-of-choice laws	Insurance reimbursement for mental health services provided by psychologists as well as physicians.
Federal Mental Health Parity Laws The Rehabilitation Act of 1973	Guaranteed equal insurance coverage for assessment and treatment services by psychologists and physicians.
Mental Health Parity Act of 1996	Prevented insurance companies from providing lesser coverage for mental health services than for physical health services.
Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (took effect January 1, 2010)	Requires insurance companies to provide the same coverage for mental and physical health services.

Models of Independent Practice	Features
Solo practice	Clinician owns the entire practice and is responsible for everything.
Group practice	Two or more clinicians offer services together, usually sharing costs.
Mixed-model practice	Two or more clinicians work

	together but are legally and financially independent.
Prescription Privileges Movement	Pros and Cons
Would allow specially trained clinical psychologists to prescribe psychotropic medication for their clients	+ Would be efficient given that most clinicians consult with physicians about clients’ medication needs. + Might increase clients’ access to medication services. −Training to prescribe may be inadequate to assure client safety. −May lead psychologists to overemphasize biological factors in clients’ problems. −May cause psychotherapy to be offered less frequently.

Test Yourself

1. Insurance companies and managed-care systems have established ___________, which list those professionals eligible to receive reimbursement for mental and physical health services.

2. Clinical psychologists in private practice tend to earn ____ than clinicians in other kinds of workplaces.

3. The training psychologists received in order to prescribe drugs has been criticized for focusing too little attention on ______________________.

You can find the answers in the Answer Key at the end of the book.

Professional Multicultural Competence

Section Preview Clinical psychologists are becoming increasingly aware of how race, ethnicity, gender, sexual orientation, and many other aspects of human diversity can influence clinical practice and outcomes. This section reviews the efforts being made to enhance clinicians' multicultural competence.

As mentioned in Chapter 1, the population of the United States is more diverse than ever, and becoming more so. It is expected that the 2020 U.S. census will find more than half of all children to be from ethnic minority groups, and that by 2044, racial minority groups will collectively constitute a slight majority of the American population (U.S. Census Bureau, 2015), leading to a non-Hispanic white minority population of about 49.9% (Frey, 2018). The field of clinical psychology is responding to these changes in several ways.

One of them involves attempts to increase diversity within the ranks of professionals. Once a white male-dominated profession, clinical psychology has become far more diverse. The percentage of clinicians who are women and/or members of racial and ethnic minority groups has increased dramatically (see Table 1.2 in Chapter 1). This growing diversity is likely to continue as graduate training programs in clinical psychology continue their efforts to recruit, train, and retain students whose sociocultural backgrounds are fully representative of the U.S. population (Hough & Squires, 2012).

Regardless of their own demographic characteristics, practicing clinicians are being encouraged to increase their **multicultural competence**,

an awareness of the existence and impact of racial/ethnic/cultural and other individual differences so as to become more effective when working with diverse client populations. Clinicians must remember that it is sometimes appropriate to alter certain assessment and treatment methods to make them more effective for clients from particular racial/ethnic minority groups (Castro, Barrera, & Steiker, 2010).

Clinical psychology graduate students, too, are being trained to deal competently with issues of diversity and multiculturalism that go beyond gender, race, and ethnicity. They must learn to adjust clinical practice to meet the needs of clients who are poor (David & Messer, 2011), who are from various religious and spiritual backgrounds (Saunders, Miller, & Bright, 2010), who were born outside the United States (Swierc & Routh, 2003), and who have physical challenges (Williams & Abeles, 2004). There is also a need to be sensitive to clients' sexual orientation (Biaggio et al., 2003) and to develop competence in working with same-sex couples, for example (Riggle & Rostosky, 2005). There is also a growing awareness of the needs of transgendered and other gender-diverse clients (Mizock & Fleming, 2011).

Concern about all of these issues, and the need for training in diversity, led to the development of the APA's 2003 *Multicultural guidelines: Education, research, and practice* (American Psychological Association, 2003). These guidelines have since been updated and retitled *Multicultural guidelines: An ecological approach to context, identity, and intersectionality* (American Psychological Association, 2017e; see Table 15.6).

Table 15.6 APA Multicultural Guidelines

The APA's original multicultural guidelines were updated in recognition of the significant growth in research and theory regarding the multicultural

contexts in which clinical psychologists now practice. Like the preamble and principles of the APA ethics code, these guidelines are aspirational, not legally enforceable, but nevertheless provide an important framework for contemporary practice in clinical psychology.

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1. Psychologists seek to recognize and understand that identity and self-definition are fluid and complex, and that the interaction between the two is dynamic. To this end, psychologists appreciate that intersectionality is shaped by the multiplicity of the individual's social contexts.

2. Psychologists aspire to recognize and understand that as cultural beings, they hold attitudes and beliefs that can influence their perceptions of and interactions with others as well as their clinical and empirical conceptualizations. As such, psychologists strive to move beyond conceptualizations rooted in categorical assumptions, biases, and/or formulations based on limited knowledge about individuals and communities.

3. Psychologists strive to recognize and understand the role of language and communication through engagement that is sensitive to the lived experience of the individual, couple, family, group, community, and/or organizations with whom they interact. Psychologists also seek to understand how they bring their own language and communication to these interactions.

4. Psychologists endeavor to be aware of the role of the social and physical environment in the lives of clients, students, research participants, and/or consultees.

5. Psychologists aspire to recognize and understand historical and contemporary experiences with power, privilege, and oppression. As such, they seek to address institutional barriers and related inequities, disproportionalities, and disparities of law enforcement, administration of

criminal justice, educational, mental health, and other systems as they seek to promote justice, human rights, and access to quality and equitable mental and behavioral health services.

6. Psychologists seek to promote culturally adaptive interventions and advocacy within and across systems, including prevention, early intervention, and recovery.

7. Psychologists endeavor to examine the profession's assumptions and practices within an international context, whether domestically or internationally based, and consider how this globalization has an impact on the psychologist's self-definition, purpose, role, and function.

8. Psychologists seek awareness and understanding of how developmental stages and life transitions intersect with the larger biosociocultural context, how identity evolves as a function of such intersections, and how these different socialization and maturation experiences influence worldview and identity.

9. Psychologists strive to conduct culturally appropriate and informed research, teaching, supervision, consultation, assessment, interpretation, diagnosis, dissemination, and evaluation of efficacy as they address the first four levels of the Layered Ecological Model of the Multicultural Guidelines.

10. Psychologists actively strive to take a strength-based approach when working with individuals, families, groups, communities, and organizations that seeks to build resilience and decrease trauma within the sociocultural context.

Many of these guidelines can be conceptualized by the construct of *openness to the other*, which reflects individuals' ability to remain open to ideas, concepts, thoughts, feelings, and perspectives of others who are

different from themselves (Fowers & Davido, 2006). It is all part of efforts in the field of clinical psychology to improve the educational, research, and practice standards of psychologists with attention toward multicultural competence.

Multicultural competence
An awareness of the existence and impact of sociocultural differences that helps clinicians be more effective when working with diverse client populations.

Thinking Scientifically Does Cultural Competence Improve Therapy Outcomes?

Developing one's cultural competence makes sense from an ethical and sociopolitical standpoint (Forehand & Kotchick, 1996), but does it increase the effectiveness of therapy with clients from diverse backgrounds?

What am I being asked to believe?

People of color tend not to seek mental health services as readily as other groups do (e.g., Smith & Trimble, 2016; Villatoro, Morales, & Mays, 2014). Some clinicians suggest that these peoples' reluctance stems in part from the fact that standard forms of psychological treatment are typically based on methods and goals that expect clients to fully disclose their most private thoughts and actions, to seek personal fulfillment rather than social approval, and to meet other expectations that may be incompatible with the clients' cultural values (e.g., Iskandarsyah et al., 2013). Other barriers to mental health care for people of color include language differences, lack of transportation and child-care options, difficulty taking time off work, bias and discrimination in treatment settings, and concerns about costs (National Conference of State Legislatures, 2018; see also Table 4.2). These observers suggest that therapy outcomes with people of color would be improved if treatments were adjusted to make them relevant to, and compatible with, the values and experiences of people in these minority groups (e.g., Hall, 2001).

What kind of evidence is available to support the claim?

There is indeed evidence suggesting that **culturally adapted treatments** are more effective than standard treatments for ethnically diverse clients. These culturally adapted treatments are evidence-based interventions that have been systematically modified to make them more compatible with clients' cultural patterns, meanings and values (Bernal et al., 2009). At least a dozen meta-analyses of studies comparing standard forms of therapy with culturally adapted ones showed that the adapted versions—in which, for example, therapists used culturally appropriate metaphors and culturally consistent expressions—were more helpful for minority group clients (e.g., Chowdhary et al., 2014; Hall et al., 2016; Smith, Rodriguez, & Bernal, 2011; van Loon et al., 2013).

Culturally adapted treatments

Evidence-based treatments that have been systematically modified to make them more compatible with clients' cultural practices, beliefs and values.

Are there alternative ways to interpret the evidence, including those that my biases and preconceptions might have kept me from seeing?

Impressive as it is, this evidence also shows that the outcome differences between culturally adapted and standard therapy vary considerably—from near zero to quite large—and on average is only moderate (Hall et al., 2016; Huey et al., 2014; Smith & Trimble, 2016; Tao et al., 2015). The size of the differences depends on many factors, including client age, type of disorder, the racial/ethnic match between client and therapist, language spoken in therapy, and research design (e.g., Rathod et al., 2018). In other words, culturally adapted interventions may not be superior to standard interventions for all clients and all disorders, as was the case in a recent study of treatment for schizophrenia (Degnan et al., 2018), and in a review of culturally adapted treatments for Hispanics (Benuto & O'Donohue, 2015).

It is important to realize that the moderate superiority of culturally adapted vs. standard treatment does not mean that standard evidence-based treatments are *not* effective. As described in Chapters 7 and 9, the standard forms of many evidence-based therapies are effective with many different populations, including people of color, which may help explain why supplementing them with elements derived from cultural competency training may not add much to their overall effectiveness (Hayes et al., 2016; Huey et al., 2014). Indeed, not all clients from diverse backgrounds require culturally adapted

treatment, especially those who are fully acculturated into majority societal views and practices (Schwartz et al., 2010).

Although the most comprehensive analyses available find that the effects of culturally adapted versions of evidence-based treatments are only moderately better than those of standard versions (Rathod et al., 2018), there is strong support for the value of culturally adapted treatment when compared to "usual care" (meaning no special intervention).

What additional evidence would help us to evaluate the alternatives?

Numerous reviewers have pointed out serious methodological weaknesses in research on the value of culturally adapted treatments (e.g., Helms, 2015; Huey & Polo, 2008; Rathod, et al., 2018). One of the most important of these is that, because there is no clear definition of exactly what "cultural adaptation" means, each research team defines and conducts it differently, creating procedural variability that leads to uncertainty about exactly what is being evaluated. Answering the question of whether culturally adapted interventions have special benefits for ethnically diverse clients will require randomized controlled trials (see Chapter 7) which feature more rigorous research designs.

It will also be important to explore what is known as the "dose-response" effect. That is, do greater degrees of cultural adaptation lead to greater increases in an evidence-based treatment's effectiveness with people of color? A related question concerns the fact that cultural adaptation of psychological treatments usually involves changing how they are implemented (e.g., the way therapists interact with clients) rather than changing the treatments' most basic methods and content (Chowdhary et al., 2014). Is one approach better than the other? Is it best to combine the two?

Another line of research is suggested by critics who wonder whether better results might be obtained with people of color by developing new treatment packages that are based on each cultural

group's identity, views about psychopathology, and experiences with discrimination, rather than trying to adapt standard treatments that reflect an entirely different cultural context (Hall, Yip, & Zárate, 2016; Hwang, 2006).

We also don't yet know whether culturally adapted standard treatments—or new ones aimed at particular groups—would lead to especially good outcomes for clients who display *ataques de nervios*, *kyol goeu*, *koro*, and other disorders usually seen only in those groups (Dzokoto & Adams, 2005; Garlipp, 2008; Hinton, Um, & Ba, 2001; Lizardi, Oquendo, & Graver, 2009).

Finally, we need to better understand the factors that underlie the moderately better outcomes reported in some studies of culturally adapted vs. standard treatments. Is it the therapist's multicultural competence or something else? Among therapists with similar skills and experience, degree of multicultural competence should predict treatment outcome, but when measured by self-ratings, it doesn't. What *does* correlate strongly with outcomes are clients' *perceptions* of their therapist's cultural competence (Soto et al., 2018). Why should this be? One suggestion that merits research attention is that when clients feel that their therapists understand and respect their cultural values and needs, the therapeutic relationship is strengthened. This, in turn, may lead to improvements in clients' motivation and participation in treatment and, thus, to improved outcomes (Tao et al., 2015).

What conclusions are most reasonable given the kind of evidence available?

The effectiveness of evidence-based psychotherapies seems to be at least moderately improved for people of color when the treatments are adapted to align with clients' cultural values and experiences and when delivered by therapists whose clients perceive them as demonstrating multicultural competence. However, people of color can often also be effectively treated through standard forms of evidence-based methods (Bernal et al., 2009). Nevertheless, there is little reason to think that culturally sensitive and culturally-adapted methods impair the effects of treatment (assuming the key active ingredients supporting behavior change are retained), so understanding and following multicultural guidelines should still be a part of the culturally competent clinician's skill set (Sue & Sue, 2016).

A Case Study of Culturally Competent Therapy

At around the time that James Jackson began client-centered therapy with Dr. Goldberg (see Chapter 8), he had been spending almost every afternoon at a local bar where he became friends with a 45-year-old Mexican American man whom we will call "Alejandro Alvarez." Like James, Alejandro had a wife and three children, and had recently lost his job. He was the first in his family to be born in the United States and also the first to graduate from college. After going on to earn a master's degree in mechanical engineering, he worked at an automobile company for 23 years. When he was suddenly laid off, Alejandro began a downward spiral of drinking too much, "moping around the house," withdrawing from his family, feeling exhausted, but also having trouble sleeping. At his wife's insistence, he had a physical examination, after which his primary care physician encouraged him to see a psychotherapist for what appeared to be depression. Alejandro did not accept this diagnosis and told James he thought therapy would be an expensive waste of time.

At first, James didn't mention that he, too, had been skeptical about the value of psychotherapy, but that his sessions with Dr. Goldberg were helpful. As he continued to feel better about himself, and to spend less time at the bar, James decided to tell Alejandro about his treatment experience and suggested that getting some therapy might not be such a bad idea. Amazed and impressed, Alejandro called his physician, who encouraged him to call a clinical psychologist named Jack Belkin (not his real name). During that initial call, Dr. Belkin sensed Alejandro's reservations about entering therapy and so used a motivational interviewing approach (see Chapter 8) to start exploring Alejandro's ambivalence about making changes in his life. When

asked if he speaks Spanish, Alejandro said that he did, but mentioned with sadness in his voice that his children preferred not to.

Following up on this language question during their first treatment session, Dr. Belkin found that Alejandro identified equally with both Mexican and American cultures; he had long enjoyed the food, music, entertainment, and family activities of each. He also spoke about the importance of respect and for "doing for the family."

On the basis of further assessment through interviews and testing with the Beck Depression Inventory and the MMPI-2-RF (see Chapter 5), Dr. Belkin confirmed that Alejandro was experiencing depression in the severe range and anxiety in the moderate range. The things Alejandro said about himself, such as "A good man is a provider—I am not a provider," and "I have let my family down—I am useless," were consistent with the cognitive biases associated with depression, but he also had many strengths on which to build, including the fact that he was bright and loved his family.

On the basis of this clinical assessment, Dr. Belkin chose to employ cognitive behavior therapy, an evidence-based treatment for major depression (see Chapter 9), but in a modified form designed to incorporate Alejandro's culturally influenced values and belief system. This meant focusing on three values that are consistent with the Latino culture and meaningful to Alejandro: *familismo* (the importance of family), *personalismo* (valuing trust and warmth in interpersonal relationships), and *respeto* (showing genuine respect). Dr. Belkin's efforts to infuse these cultural values into his work included enhancing rapport by speaking Spanish whenever he could, and also to show respect by using more formal pronouns (e.g., "usted" rather than "tu" to mean "you"). Further, in early assessment sessions where symptoms of disorder usually take center stage, Dr. Belkin honored the importance of

Alejandro's family relationships by patiently allowing him to describe at length the details of his family and its history. When the time was right to discuss the specifics of Alejandro's problems, Dr. Belkin showed respect by asking for permission to inquire about topics that might be construed as weakness or inadequacy in Alejandro's culture. For example, instead of saying something like "Please tell me about what your depression feels like," Dr. Belkin said "May we talk about the 'down' or perhaps depressed feelings that you have been experiencing?" All of these efforts helped Alejandro to be more comfortable and to engage with therapy.

During 12 sessions of cognitive behavior therapy, Dr. Belkin continued to employ culturally sensitive strategies designed to help Alejandro replace his negative cognitions ("unhelpful thoughts") with more adaptive, balanced ones and increase participation in rewarding activities that could help him to reengage with his family and friends. Although family members are not usually included in CBT treatments with adults, Dr. Belkin felt that, in this case, the importance of family justified inviting Mrs. Alvarez to participate in some sessions. She was able to engage in therapy quite successfully and much to her husband's benefit.

By the end of treatment, Alejandro reported almost no depressive symptoms and he showed much higher levels of energy than before treatment. Six months after the final session, Mr. Alvarez called the therapist to report that he had found a new job in the automobile industry and that he felt proud and satisfied at his new accomplishments—largely because being employed meant that he could once again provide for his family.

Source: Adapted from Gonzalez-Prendes, A. A., Hindo, C., & Pardo, Y. (2011). Cultural values integration in cognitive behavior therapy for a Latino with depression. *Clinical Case Studies, 10,* 376–394.

In Review Professional Multicultural Competence

<table>
<tr><td colspan="2">What is Multicultural Competence?
Awareness of the existence and impact of racial/ethnic/cultural differences so as to become more effective when working with diverse client populations.</td></tr>
<tr><td>Need for Multicultural Competence</td><td>Evidence</td></tr>
<tr><td>As the U.S. population changes, clinical psychologists will work with an increasingly diverse range of clients</td><td>As the size of many racial and ethnic minority groups increase, by 2045, non-Hispanic whites will make up slightly less than half of the U.S. population.</td></tr>
<tr><td>Efforts to Promote Multicultural Competence</td><td>Examples</td></tr>
<tr><td>Diversity training</td><td>Continuing education courses for practicing clinicians.
Specialized courses and training experiences in clinical psychology training programs.</td></tr>
<tr><td>APA Guidelines for Multicultural Competence</td><td>Includes 10 statements describing clinical psychologists' aspirations for providing the highest quality services to diverse client populations.</td></tr>
<tr><td colspan="2">Test Yourself</td></tr>
</table>

1. There has been a dramatic increase in the number of clinical psychologists who are _______ and _________.

2. Research on culturally adapted forms of evidence-based psychotherapies shows that such adjustments _________improve treatment outcomes.

3. Like the ethical principles of the APA Ethics Code, the APA's Multicultural Guidelines __________legally enforceable.

You can find the answers in the Answer Key at the end of the book.

The Future of Clinical Psychology

Section Preview This section highlights a number of trends in clinical psychology that we think will appear or continue in the future, including changes in training, the impact of positive psychology, spirituality, and technological advances, the broader dissemination of effective clinical methodology, the integration of treatment methods, the growth of interdisciplinary science, and outreach to national and international communities.

In this chapter and in others, we have discussed some future directions in the evolution of clinical psychology, such as the growth of evidence-based practice, the push for prescriptive authority for psychologists, and increased emphasis on multicultural competence. There are other changes on the horizon, too, so let's consider a few of the most important of them.

Training

Controversy will likely continue over the question of how clinical psychologists should be trained. Differences in the philosophy and training agendas of doctoral training programs based on the clinical scientist, scientist–practitioner, and practitioner–scholar models show no signs of rapid resolution. We expect that some disconnect between Ph.D. and Psy.D. training programs will continue, but we hope that this gap will close somewhat as programs focus more on evidence-based practices that can be applied in multiple domains (Sturmey & Hersen, 2012a, b). We agree with Richard McFall (2006), who argued that clinical psychology training programs must not allow themselves to become narrowly focused vocational schools, but rather that they need to train students to have a variety of skills, grounded in empirical science, that can be applied in a variety of settings. This kind of training is especially important because the future of clinical psychological research, practice, education, dissemination, and implementation will increasingly depend on integration of therapy methods and collaboration with other professionals.

Psychotherapy Integration

As mentioned in Chapter 1, **psychotherapy integration** is the process of combining elements of various clinical psychology theories in a systematic manner. As noted in Chapter 8, for example, relational psychodynamic approaches combine aspects of psychodynamic and humanistic theory and technique, and cognitive behavior therapies obviously combine cognitive and behavioral methods. A number of other integrative therapies are gaining popularity, including *integrative problem-centered therapy* (Pinsof, 1994), *cognitive-affective-relational-behavior therapy* (Goldfried, 2006), and *integrative behavioral couple therapy* (McGinn, Benson, & Christensen, 2011).

Psychotherapy integration
The process of combining elements of various clinical psychology theories in a systematic manner.

We think that integration can be a good idea when done in an evidence-based way (i.e., drawing from a strong case conceptualization, empirical research evidence, and the monitoring of client outcomes) and there are a number of ways to achieve it (Stricker & Gold, 2006). For example, clinicians can select assessment and treatment methods from all those available in the field and apply them to particular clients based on the clinician's understanding of the research evidence that supports various

change principles (Goldfried, Glass, & Arnkoff, 2011). Conversely, clinical researchers are integrating different psychological theories of change and creating new evidence-based therapies, such as the *acceptance and commitment therapy*, *dialectical behavior therapy*, and *multisystemic therapies* discussed in Chapters 7 and 9 (Goldfried, Glass, & Arnkoff, 2011). In addition, as also noted in Chapter 7, researchers and clinicians are searching for *common factors*, such as having a strong and stable therapeutic relationship, that are consistent across many types of therapy and associated with effective outcomes (Davis, Lebow, & Sprenkle, 2012).

In short, the predominant theme in psychotherapy integration is to find evidence-based practices that can be applied to specific clients at specific times (Goldfried, Glass, & Arnkoff, 2011). You can find much more information about psychotherapy integration in sources such as the *Journal of Psychotherapy Integration* (Stricker, 2010) or the *Handbook of Psychotherapy Integration* (Norcross & Goldfried, 2005).

Interdisciplinary Science and Practice

A colleague of ours likes to compare the current bickering in clinical psychology—about which training model is best, and what kind of evidence is good enough to support evidence-based practice—with the arguments that blacksmiths might once have had about how to make the best horseshoe. Those arguments became largely irrelevant once automobiles came on the scene, and similarly dramatic developments in other fields of science may have similarly disruptive effects on clinical psychology if clinical scientists ignore or fail to engage with those developments. After all, clinical psychology is only one of the sciences that are trying to understand human behavior and if the field does not change with the times, it could well go the way of the blacksmiths. We predict that clinical psychology will need to become more integrated with disciplines such as genomics, genetics, behavioral genetics, social neuroscience, cognitive-affective neuroscience, developmental neuroscience, comparative psychology (studies of nonhuman animals), and other areas of science, technology, engineering, and math (STEM; Cacioppo et al., 2007; Price, 2011) as well as with sociology and other disciplines that explicitly consider identity and structural contributors to inequality.

Growing in parallel with these patterns of interdisciplinary science are patterns of interdisciplinary practice in which clinical psychologists work with counseling psychologists, school psychologists, social workers, psychiatrists, educators, the clergy, and other professionals to assess clients' problems and plan and implement treatment programs, especially in complex cases where several specialists can each make unique contributions (Bray,

2011). As a result, there is now an increased demand for clinical psychologists who are knowledgeable enough to work on interprofessional health-care teams (Robiner & Petrik, 2017), and clinical training models will have to adjust to meet that demand.

Positive Psychology

Personal characteristics such as optimism (Carver, Scheier, & Segerstrom, 2010; Carver & Scheier, 2014) and gratitude (Wood, Froh, & Geraghty, 2010) are of increasing interest to researchers who study people's sense of well-being. As we mention in Chapter 3, such characteristics are central to the *positive psychology* movement, which focuses on understanding and promoting personal growth and human potential (Seligman, 2019). We think positive psychology will play an increasingly important role in clinical psychology (McNulty & Fincham, 2012; Wood & Tarrier, 2010) because, rather than dwelling solely on the symptoms of disorder when planning treatments, positive psychology recognizes and emphasizes clients' strengths, including their resilience, positive character traits, good health, and adaptive skills and talents (Rashid & Seligman, 2018; Ruini, 2017). In dealing with posttraumatic stress disorder, for example, positive psychology interventions might include efforts to promote *posttraumatic growth*, which refers to beneficial psychological changes (such as appreciating the good things in life or experiencing stronger family ties) that sometimes occur after surviving a traumatic event or a major illness (Sawyer, Ayers, & Field, 2010; Xu et al., 2016).

Positive psychology's deemphasis on symptoms in favor of highlighting client strengths, well-being, and potential for recovery may also help to reduce the stigma that some people still associate with receiving mental health services (Hinshaw, 2007; Vertillo & Gibson, 2014).

Positive psychology has also been applied to preventing psychological problems before they occur, especially through making social and

environmental changes (Biglan et al., 2012; Biswas-Diener, 2011; Muñoz, Beardselee, & Leykin, 2012; Yoshikawa, Aber, & Beardslee, 2012; see our discussion in Chapter 10).

The goals of positive psychology interventions sound good, but critics question whether these interventions really offer anything new, how scientific they are, and if their outcomes are significantly better than those of standard evidence-based interventions (Davis et al., 2016; Seligman, 2019). They also worry that focusing mainly on positive emotions may cause clients to miss out on the benefits that sometimes come from certain negative moods. For example, modest doses of sadness can motivate us toward constructive problem-solving and encourage us to analyze life's problems more deeply (Forgas, 2013).

Spirituality

Traditionally, clinical psychologists and clinical researchers have not included spirituality and religiosity in the course of their professional work. For example, early measures of coping methods did not include space for clients to mention that they used prayer or other spiritual methods to deal with stressors, and even the current version of the *Ways of Coping* questionnaire (Folkman & Lazarus, 1988) lists only two religiously oriented options, namely, “I prayed” and “I hoped for a miracle.” As is true of politics or any other value-laden issue, most clinicians are reluctant to mention religion or spirituality during psychological assessment and treatment unless clients mention it as being an important part of their lives. This reluctance is based on concerns that raising questions about spirituality might impair the therapy relationship, especially for nonreligious clients who might wonder if they will be subjected to some sort of conversion effort, or for members of the LGBTQ community who might associate religion with intolerance of their sexual orientations (Yarhouse & Tan, 2005).

However, despite survey data suggesting declining religiosity in the U.S. population in recent years, America is still more devout than most other industrialized nations (Pew Research Center, 2018), and clinicians still recognize religious issues in therapy. The risk and resilience literature suggests that having a guiding faith and having a supportive faith-based community can serve as a protective factor for youth who live in harsh psychosocial environments (Shaffer, Coffino, Boelcke-Stennes, & Masten, 2007). Further, prayer and spirituality have been identified as effective mechanisms for coping with cancer (Zaza, Sellick, & Hillier, 2005), HIV and

AIDS (Cotton et al., 2006), and the long-term effects of cardiac surgery in the elderly (Ai et al., 2010). The practice of prayer has also been associated with a generally higher quality of life and fewer physical and mental health problems (Bantha et al., 2007), though there is little or no evidence to support the value of intercessory prayer, that is, when a person or group prays for one particular person (Masters, Spielmans, & Goodson, 2006).

We expect that there will continue to be a separation between empirical psychological science and faith-based beliefs, but we also expect that more research on topics related to spirituality will give clinicians a broader understanding of religious clients' coping resources as well as of their special concerns, such as forgiveness, redemption, and sin. As part of efforts to enhance their own multicultural competency, clinicians are also likely to seek out resources that can help them to learn more about how spiritual beliefs differ across religions and cultures (Raiya & Pargament, 2010) and how these beliefs can be integrated with secular evidence-based approaches (Rosmarin, 2018).

Technology

As in all other areas of 21st century culture, technology will play an increasing role in clinical training, research, and practice. For example, more and more undergraduate clinical psychology courses will be offered online (Bachman & Stewart, 2011). Although there are currently prohibitions against APA-accredited programs being taught solely online, it is plausible that significant components of graduate training will be provided through distance learning technology (Murphy et al., 2007).

Similarly, as we discuss in Chapter 10, clinicians will find themselves delivering more mental health services—and conferring with professional colleagues—through the internet via smartphones and other hand-held devices, computers, videoconferencing, and blogs. These *telehealth* or *ehealth* services can be especially helpful when dealing with clients who live in rural areas or other remote locations (Eonta et al., 2011; Waltman et al., 2019). Technological innovation such as virtual reality-assisted treatments, computer-based assessment, and neuroimaging will also be expanding the scope and efficiency of clinical services.

So far, research suggests that enhancing evidence-based practices with new technologies can increase the effectiveness of those practices (Clough & Casey, 2011; Harwood et al., 2011b), but leaders in clinical psychology want to ensure that psychologists continue to use them in accordance with ethical practice (APA, 2013d; see Table 15.7).

Table 15.7 APA Guidelines for the Practice of Telepsychology

The American Psychological Association has developed the following aspirational guidelines for the practice of telepsychology (American

Psychological Association, 2013d).

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1. Psychologists who provide telepsychology services strive to take reasonable steps to ensure their competence with both the technologies used and the potential impact of the technologies on clients/patients, supervisees, or other professionals.

2. Psychologists make every effort to ensure that ethical and professional standards of care and practice are met at the outset and throughout the duration of the telepsychology services they provide.

3. Psychologists strive to obtain and document informed consent that specifically addresses the unique concerns related to the telepsychology services they provide. When doing so, psychologists are cognizant of the applicable laws and regulations, as well as organizational requirements, that govern informed consent in this area.

4. Psychologists who provide telepsychology services make reasonable efforts to protect and maintain the confidentiality of the data and information relating to their clients/patients and inform them of the potentially increased risks of loss of confidentiality inherent in the use of the telecommunication technologies, if any.

5. Psychologists who provide telepsychology services take reasonable steps to ensure that security measures are in place to protect data and information related to their clients/patients from unintended access or disclosure.

6. Psychologists who provide telepsychology services make reasonable efforts to dispose of data and information and the technologies used in a manner that facilitates protection from unauthorized access and accounts for safe and appropriate disposal.

7. Psychologists are encouraged to consider the unique issues that may

arise with test instruments and assessment approaches designed for in-person implementation when providing telepsychology services.

8. Psychologists are encouraged to be familiar with and comply with all relevant laws and regulations when providing telepsychology services to clients/patients across jurisdictional and international borders.

Dissemination

At various points throughout this book, we have emphasized the importance of mental health literacy—public understanding about mental health issues (Jorm, 2012). Perhaps the most important way to promote this literacy is to have clinicians and clinical researchers communicate with the public more often and more clearly. Known as *dissemination*, the sharing of information with other professionals and with the public is an important aspect of conducting research—especially outcome studies of psychological treatments. (See Chapter 10 for more on the impact of dissemination and implementation science.)

Indeed, it has been argued that researchers should write two parallel papers when they have made important findings—a scholarly article to be published in a professional journal and a more accessible article that could be published in a popular magazine (Sommer, 2006). A number of APA presidents have supported the idea of making psychology more accessible to the general public and to "make psychology a household word" (Levant, 2006). Some have even suggested that psychological scientists should launch direct-to-consumer marketing plans to share knowledge about evidence-based treatments with consumers and potential clients (Santucci, McHugh, & Barlow, 2012). Efforts to increase mental health literacy are gaining momentum and we hope they will continue, because once empirical evidence is strong enough to justify useful conclusions, that evidence can be applied more quickly if dissemination occurs both at the professional and the public levels (Kazdin & Rabbitt, 2013; Michalak & Heidenreich, 2018).

Outreach to National and International Communities

Mental disorders are a leading cause of disability in countries all over the world (Whiteford, Ferrari, & Degenhardt, 2016), yet a great many people who need mental health services do not receive them (Wang et al., 2007). Among many underserved populations are people with chronic mental illnesses, people in rural areas, substance abusers, and older adults, but the largest *disparities* between those who do and do not receive needed services are seen in ethnic minority groups (Wang et al., 2007). Clinical researchers and practitioners are interested in decreasing these disparities and in increasing access to quality mental health care for everyone, everywhere. In the United States, the National Institute of Mental Health has directed training grant funds toward these “underserved groups” and therefore, we hope that services for these groups will continue to increase.

University of Toronto psychologist Dr. Daisy Singla partners with health care systems in low resource settings such as rural Uganda and India, to help adapt and disseminate evidence-based mental health treatments for populations that are often underserved.

Increased attention is also being focused on another underserved population, namely veterans and active duty military personnel (Gates et al., 2012). For example, efforts are being made to increase troops' resiliency before they are deployed to combat zones (Casey, 2011), but these programs need further evaluation, because there is some evidence that resilience training in a deployed environment may actually reduce resilient thinking and morale (Carr et al., 2013). Other efforts have focused on increasing utilization of mental health services for personnel who need them when they return from

deployment (Maguen et al., 2010). This includes programs to reduce the stigma that some veterans still associate with receiving mental health services (Bryan & Morrow, 2011). Efforts to increase utilization of mental health services are vital because rates of PTSD, depression, and suicide are all too high among active duty, postdeployment, and retired members of the military (Bryan & Morrow, 2011; Gates et al., 2012; Hester, 2017). Some programs make use of telehealth channels; one example is a multimedia wellness program (afterdeployment.org) specially designed for military personnel returning from combat (Bush et al., 2011).

Clinical psychologists are also working to help individuals and communities in other countries, including by working to reduce human trafficking (Clay, 2011a), engaging in human rights causes (Willyard, 2010), and addressing the needs of refugee populations (Kaczorowski et al., 2011). They are also involved in combating global climate change (Swim et al., 2011), whose stressful consequences have been associated with PTSD, anxiety, depression, and substance abuse, as well as a sense of helplessness or fatalism, and intense feelings of loss. As the need for these global efforts continues to increase, clinical psychologists of the future are increasingly likely to participate in them.

A Final Word

Obviously, clinical psychologists are committed to finding new ways to help people that go beyond symptom reduction—including through prevention programs, influencing social policy, and focusing on recovery and personal growth. As the world has become more interconnected and interdependent, especially given recent technological advances, so too has the field of clinical psychology become more responsive to the world around it. These trends are likely to continue into the foreseeable future. There are a great many talented and dedicated individuals within clinical psychology who sincerely wish to help others and to make a difference. For that reason, we have a great deal of hope for the future of clinical psychology. We hope that this book might play a role in moving you to join in the creation of that future.

In Review The Future of Clinical Psychology

Trends	Descriptions
Training in interdisciplinary psychology	Integration of clinical psychology with other disciplines will facilitate translational research through which findings from basic sciences have an impact on applied practices.
Positive psychology	The scientific study of human flourishing, and an applied approach to optimal functioning.
Increasing use of technology	Innovations such as virtual reality–assisted treatments, technology-based assessment and treatment, and neuroimaging will expand the scope of clinical services.
Dissemination	Sharing of empirically validated conclusions with other professionals in clinical settings, and with the public.
National and international outreach	Efforts to reach such underserved populations as the chronically mentally ill, people in rural areas, substance abusers, older patients, ethnic minority groups, and active duty and retired military personnel. Efforts to reach underserved populations in other countries and to address worldwide problems such as human trafficking and climate change.
Test Yourself	

1. Emphasizing clients' strengths and virtues rather than just symptoms of disorder illustrates the influence of _________.

2. For some people, extreme weather and other aspects of __________ has been associated with anxiety, depression, and PTSD.

3. Providing consumers and potential clients with the latest information about evidence-based treatments is a form of ________.

You can find the answers in the Answer Key at the end of the book.

Chapter Summary

Many professional issues are of prime importance as clinical psychology continues to develop its scientific and professional identity in the 21st century. These include training, regulation, ethics, independence, and the need for multicultural competence.

Since the late 1940s, clinical training programs have typically followed some version of the Boulder model, a scientist–practitioner curriculum that emphasizes research and psychology's scientific foundation. Several training conferences since that time have reaffirmed the Boulder model, but training models that emphasize professional skills and de-emphasize research are also available now. Many of these are Doctor of Psychology (Psy.D.) programs and practice-oriented Ph.D. programs offered in psychology departments or in freestanding schools of professional psychology. There is also growing interest in programs that are strongly research oriented, and a new accreditation system, the Psychological Clinical Science Accreditation System (PCSAS), now exists to highlight programs that have rigorous research training in conjunction with clinical training. All these training models are being affected by an internship imbalance brought about because there are often too many applicants for the internships available.

Professional regulation of clinical psychologists comes in several forms, including: (a) laws that establish criteria for who may use the title of "psychologist" (certification laws) and perform psychological services (licensing laws); (b) laws establishing therapists' duty or option to warn; and (c) lawsuits alleging clinical malpractice. In 2010, APA developed a model

legislative act to try to standardize licensure across the nation, but for it to have a major impact, all or most states will have to adopt its recommendations.

The code of ethics in psychology is unique because it was developed on the basis of psychologists' experiences with real ethical dilemmas. The current version, called *Ethical Principles of Psychologists and Code of Conduct,* includes a Preamble, General Principles, and a large number of Ethical Standards covering a wide range of specific topics, from advertising services and testing to rules about confidentiality and sexual contact with clients.

The struggle of clinical psychology to gain and retain its status as a profession that is authorized to offer independent services has been long, difficult, and continuing. It first involved the right of clinicians to offer psychotherapy. Later, the issue was whether clinical psychologists could practice independently in hospitals and whether psychologists should be eligible for reimbursement under various public, private, and prepaid mental health insurance plans. The Mental Health Parity Act of 2009 laid many of these issues to rest because mental health services are now covered in the same manner as physical health services. There is growing interest in psychologists gaining prescriptive authority, but there are pros and cons to this venture.

Today, the field of clinical psychology has a greater commitment to understanding diversity, and there is a strong emphasis on developing multicultural competence. The field confronts the formidable challenge of shaping its training programs and service functions to meet the needs of diverse client populations.

16

Getting into Graduate School in Clinical Psychology

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Contents

What Types of Graduate Programs Will Help Me Meet My Career Goals?

Am I Ready to Make the Commitment Required by Graduate Programs at This Time in My Life?

Are My Credentials Strong Enough For Graduate School in Clinical Psychology?

I Have Decided to Apply to Graduate School in Clinical Psychology. What Should I Do Now?

Chapter Preview

Students ask a number of questions when they are thinking of applying to graduate school in clinical psychology. In this chapter, we hope to answer some of those questions and to pose some others that potential applicants need to consider. We know this is an anxiety-provoking process for most students, so we want to demystify it as much as possible! We begin by addressing questions related to deciding whether to apply to graduate school in clinical psychology, and then discuss the logistics of doing so. We dispense with our usual Section Previews and Section Summaries and present instead a “frequently asked questions” format in which headings provide the questions and the paragraphs that follow provide the answers.

What Types of Graduate Programs Will Help Me Meet My Career Goals?

In thinking about a career in psychology, the first questions you must ask yourself are, “What type of career do I want?” and “What types of graduate programs are available to meet my career goals?” The field of psychology offers many career options, so we suggest that you read the APA’s free brochure called “Psychology: Scientific Problem Solvers—Careers for the 21st Century.” You can find it online at www.apa.org/careers/resources/guides/careers.pdf. For more detailed information, there are entire books written about career options for psychology undergraduates (e.g., Morgan & Korschgen, 2013). Of course there are many career options available within clinical psychology itself, and the Council of University Directors of Clinical Psychology has put together some excellent resources on selecting and applying to programs that will be a good fit for you. You can access the resources at http://clinicalpsychgradschool.org/.

Research Versus Clinical Emphasis?

All university-based graduate programs in clinical psychology provide training in research as well as in clinical service delivery, and most provide training related to teaching psychology as well, but there are differences in emphasis from one institution to another. It is worth your effort to learn about each program's emphasis when you are gathering other information about their programs. Subtle differences in a program's description (e.g., scientist–practitioner vs. clinical scientist; see Chapter 15) may reveal a great deal about the program's training emphasis.

If your primary career interest is in *research* on mental health, psychopathology, prevention, and treatment, then a Ph.D. program in clinical psychology is probably your best option. These programs typically offer the most training in research, the most time focused on conducting research, and the widest variety of clinical research opportunities. As described in Chapter 1, clinical researchers find careers in a variety of mental health settings, hospitals, medical schools, and government, public, and private agencies. Research-oriented clinical Ph.D. programs also provide training and supervision in clinical work, so graduates of these programs typically have the option of shifting into clinical work as long as they have kept their licensure requirements up to date. In fact, most clinical psychology doctoral graduates will end up in more than one role, even if they spend the bulk of their time on research.

Certain nonclinical psychology Ph.D. programs may also provide avenues to clinical research. Graduates of programs in developmental psychology, personality psychology, cognitive neuroscience, experimental

psychopathology, or social psychology sometimes conduct research with important clinical applications (e.g., childhood psychopathology, positive psychology). These strictly research-oriented, nonclinical programs are expected to make their focus clear in their descriptive information and will typically refrain from using "clinical psychology" as a program title. These programs tend to attract fewer applicants than clinical programs do, and, though still quite difficult to get into, may be less competitive than clinical programs. However, clinical research options may be more limited in these programs than in clinical Ph.D. programs, and graduates of nonclinical programs will *not* be eligible for psychotherapy licensure or practice.

If your primary interest is in clinical work, especially therapy, then there are a number of options both inside and outside of clinical psychology. First, if you are most interested in doing assessment, rather than therapy, we encourage you to look into programs in school psychology, clinical neuroscience, or forensic psychology, all of which include a strong focus on assessment, though the populations their graduates mainly work with differ (e.g., children with potential learning disabilities, older adults with cognitive impairment, individuals involved with the legal system). All accredited clinical psychology programs will also include some training in assessment as well as therapy.

In Chapter 1, we describe several mental health professions other than clinical psychology whose graduates engage in assessment, psychotherapy, or counseling. These include counseling psychology, school psychology, social work, rehabilitation counseling, marriage and family therapy, psychiatry, and psychiatric nursing, among others. We do not have the space here to provide details about the graduate admission requirements for each of these fields, but you can find this information at the websites of professional organizations

such as the National Association of Social Workers, the American Psychiatric Nurses Association, the National Association of School Psychologists, and the American Association for Marriage and Family Therapy.

Also note that the U.S. Government's Bureau of Labor Statistics has a searchable database on "Occupational Employment Statistics" at www.bls.gov/oes/ that can help you compare incomes earned by people in these various professions. For instance, you can read about occupational employment and wages across different work settings for clinical, counseling, and school psychologists at https://www.bls.gov/oes/current/oes193031.htm.

M.A., Ph.D., or Psy.D.?

Many students seem to think that if they want to do clinical work, they must enter a Ph.D. program in clinical psychology. In fact, approximately four times as many students get master's degrees in psychology as get doctoral degrees (American Psychological Association, 2018b). Further, the growth of managed health-care systems has stimulated the job market at the master's-degree level for those seeking a career in direct clinical service. Thus, the master's degree in clinical psychology is a more marketable degree than it had been in the past. Further, what was seen as the biggest drawback to the master's degree—the need for continual supervision from a licensed Ph.D. psychologist—may be changing. The state of Kentucky, for example, allows master's-level psychologists to be licensed to work independently after they meet certain training and professional experience requirements. Other states, such as Florida, allow professionals with a master's degree in a mental health-related field (such as clinical or counseling psychology, or rehabilitation counseling) to seek licensure as an independently practicing mental health counselor. Thus, if you are interested in having a full-time clinical career and if you have limited interest in research training, you may want to consider pursuing a master's degree in clinical psychology or in a related field (Martin, 2011).

The master's degree does carry some limitations, though. In most states, if you want to be licensed as a psychologist (which means that you can actually use the term *psychologist* rather than another term like *counselor* or *psychological associate*), you have to have either a Ph.D. or a Psy.D.. How and whether that will change over time is uncertain, but there are reasons to

think that master’s degree guidelines may be shifting. For instance, in January 2019, the American Psychological Association prepared a report exploring the possibility of starting to accredit master’s programs.

Still, income levels are typically lower for master’s-level clinicians, and advancement opportunities are fewer. Certain career opportunities, such as being a professor at a college or university, or being awarded clinical research grants are often unavailable to those without a doctorate. Further, employment settings may be somewhat more limited for master’s-level clinicians. Thus, the doctoral degree gives you more flexibility, which can be helpful given that your career interests will likely change somewhat over your life span. However, if you are sure that you only want to do clinical work (as opposed to a combination of research and direct service), then you may want to consider earning a master’s degree so that you can begin to seek your desired job sooner. The bottom line is that this is a time of some transition for clinically related master’s degrees, so while the growth of managed-care systems has stimulated the job market at the master’s degree level, be certain that the jobs available will match your career goals before opting for a master’s degree.

At the doctoral level, you have the choice of Ph.D. and Psy.D. programs. Traditionally, the Ph.D. degree is considered the terminal degree in clinical psychology. As described in Chapter 15, Psy.D. programs tend to emphasize clinical training while reducing the emphasis on research. However, it is important to remember that Psy.D. programs themselves vary considerably. As mentioned in Chapter 1, some follow the *Boulder model* and emphasize research almost as much as some Ph.D. programs do, while others adopt the *Vail model* and emphasize research considerably less. Programs that deemphasize research still require that students acquire knowledge of

statistics and research methods, but students are usually not required to conduct an empirically based thesis or dissertation and the level of statistical training may be less intensive.

Another difference between Ph.D. and Psy.D. programs is that the latter are often not affiliated with a specific psychology department or even with a university. Freestanding professional schools generally place the least emphasis on research training. These programs are attractive to some students because they so clearly emphasize practice over research and because, for reasons described below, they generally have considerably less stringent selection criteria than Ph.D. clinical programs (see Table 16.1).

Table 16.1 Average Acceptance Rates for APA-Accredited Clinical Psychology Programs

	Freestanding Psy.D.	**University-based Psy.D.**	**Practice-oriented Ph.D.**	**Equal-emphasis Ph.D.**	**Resea orient Ph.D.**
Number of applications	227	163	155	160	183
Number of acceptances	108	58	18	16	12
Acceptance rate	50%	40%	16%	14%	7%

Source: From Sayette, M. A., & Norcross, J. C. (2018). *Insider's guide to graduate programs in clinical and counseling psychology*, 2018/2019 ed. (p. 54). New York: Guilford Press. Copyright 2018 by Guilford Press. Data drawn from Norcross, Ellis, & Sayette (2010). Used with

permission.

However, some cautionary notes are necessary. First, because these programs are in stand-alone institutions, their financial support comes mainly from students' tuition fees, and as in medical schools and law schools, the fees can be quite high and there is often little or no financial aid available. In contrast, most clinical Ph.D. programs offer their students some financial support, including tuition fee waivers and stipends as research or teaching assistants. Second, if Psy.D. programs are to turn a profit, or at least break even, they have to accept a large number of students (e.g., as many as 100) each year. This means that students may not get the same individual attention that they would in a Ph.D. program, where the entering class may include only 3 to 10 students. Finally, the relatively weaker research training in many of these programs means that graduates are less likely to find employment in research-oriented clinical positions or to combine research with their clinical work. These points are summarized in Table 16.2, which presents myths and realities about getting into doctoral degree programs in clinical psychology.

Table 16.2 Myths and Realities about Clinical Psychology Graduate Training

Topic	**Myth**	**Reality**
Graduate school acceptance rate	Anyone can get into a Psy.D. program, but it is very difficult to get into a Ph.D. program.	Among APA-accredited programs, Psy.D. programs accept about 50% of applicants—some higher, some lower. Ph.D. programs accept about 7–16% of applicants —some higher, some

		lower. Although there are more Ph.D. programs, the number of Psy.D. degrees awarded each year exceeds the annual number of Ph.D. degrees awarded.
Financial assistance	You cannot get financial aid if you attend a Psy.D. program, but all Ph.D. students get aid.	There is considerable variability in the amount of financial aid offered in Psy.D. and Ph.D. programs. While only 1% of students in *freestanding* Psy.D. programs received both a tuition waiver and financial support through an assistantship or fellowship in 2007, the figure was 17% for *university-based* Psy.D. programs. For practice-oriented Ph.D. programs, it was 42%, while for research-oriented Ph.D. programs, it was 89%.
Theoretical orientation of clinical faculty	Faculty in traditional Ph.D. programs are mostly cognitive behavioral, while those in Psy.D. programs are psychodynamic and humanistic.	A cognitive behavioral orientation is the most frequently cited one in Ph.D. *and* Psy.D. clinical programs. University-based graduate departments tend to have

		higher percentages of faculty endorsing a cognitive behavioral perspective. The percentage of faculty endorsing humanistic orientations, though lower than cognitive behavioral, is highest in freestanding schools.
Training in evidence-based practice	Psy.D. programs do not train students in empirically tested psychotherapies.	Most programs offer some training in treatments that have been defined in manuals and found efficacious in at least two well-controlled randomized clinical studies, but few require both didactic and clinical supervision in conducting these treatments. Psy.D. programs have the highest percentage of programs (67%) not requiring it.
Performance on national licensing board exam	Psy.D. students are not well prepared for the Examination for Professional Practice in Psychology (EPPP).	Psy.D. students score lower on average on the national licensing exam, but there is great variability. Higher exam scores are more reliably associated with smaller-

sized clinical programs, better faculty-to-student ratios, and traditional (Boulder model) Ph.D. curricula.

Sources: Norcross, J. C., Castle, P. H., Sayette, M. A., & Mayne, T. J. (2004). The Psy.D.: Heterogeneity in practitioner training. *Professional Psychology: Research and Practice, 35,* 412–419; 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, 4*(2), 99; Sayette, M. A., & Norcross, J. C. (2018). *Insider's guide to graduate programs in clinical and counseling psychology: 2018/2019 edition.* New York, NY: Guilford; Weissman, M. M., Verdell, H., Gameroff, M. J., Bledsoe, S. E., Betts, K., et al. (2006). National survey of psychotherapy training in psychiatry, psychology, and social work. *Archives of General Psychiatry, 63,* 925–934.

Am I Ready to Make the Commitment Required by Graduate Programs at This Time in My Life?

After exploring the career options available with master's and Ph.D. degrees, and after careful consideration of what you want to achieve, suppose you have decided that a doctoral program in clinical psychology offers you the most career flexibility and the best chance to achieve your research and clinical goals. The next question you have to ask yourself is whether you are prepared to make the major commitments in time, money, and physical and emotional energy that are required to succeed in such a program.

Time Commitments

Your typical weekly activities in a clinical psychology doctoral program will shift over time. In the first few years, it is common to take several classes each semester, but by the third or fourth year, you will probably be finished with coursework. While completing that coursework, you may work as a teaching assistant or research assistant (often for 10–20 hours per week), and participate in a clinical practicum in which you will conduct assessments, therapy, or other clinical services for 8 to 20 hours a week, depending on where you are assigned to work. In addition, you will be expected to make progress on independent research toward completion of your master's thesis and doctoral dissertation. In more research-oriented programs, you will also be expected to publish and present your research at conferences. Thus, it is not unusual for graduate students in clinical programs to work well over 40 hours per week throughout the year. Unlike many undergraduates, doctoral students view the summer as a time to focus on making progress on their research and other writing.

On average, it takes 5 to 7 years to complete a doctoral program; the first 5 or 6 years are spent in residence at the program site, and then 1 year is spent completing a full-time clinical internship. The internship is a paying job, but it does not typically pay well, so be aware that unless you have independent financial resources, completing a doctoral program means living for a number of years on low wages and perhaps taking on additional student debt. Depending on the state in which you wish to work, you may also have to take a 1- or 2-year postdoctoral position in order to obtain the necessary supervised clinical experience required for licensure. Thus, it may take

anywhere from 6 to 9 years after starting graduate school before you are ready to venture fully into the job market. Generally, the more research oriented a graduate program is, the longer it will take to complete because in addition to completing their clinical, teaching, and coursework requirements, students also need to be very productive in their research to be competitive for desirable research positions.

All in all, becoming a Ph.D. clinical psychologist is a lengthy and demanding process, so be sure it is really what you want before you start applying for training.

Financial Commitments

Given the high cost of graduate education, the majority of graduate students in doctoral programs end up borrowing money. The debt they incur varies with the type of program they attend. A 2009 survey conducted by the American Psychological Association found that approximately 90% of recent Psy.D. graduates and 61% of Ph.D. graduates had some type of debt after completing their degrees (Michalski et al., 2009), and that higher debt was associated with the more practice-oriented, less research-oriented, programs. The average debt load carried by graduates of Ph.D. psychology programs was nearly $58,000; the figure for Psy.D. graduates was nearly $103,000. Beginning salaries in clinical psychology are not high enough to make it easy to pay off these debts; it often takes 10 to15 years.

As already mentioned, many graduate programs offer their students income opportunities, usually in the form of assistantships or financial aid. Although funding has increased over the years, the median teaching assistant or research assistant stipends continue to be modest for a 20-hour-per-week position. A 2010 report found that the median pay for teaching and research assistants at public universities was between $12,000 and $13,000 for the 9-month academic year (Sayette & Norcross, 2018), though we have seen stipends rise considerably in the past decade, such that assistantships of $20,000 or more are no longer unusual at top programs. Many universities also offer fellowships and scholarships, which are usually given as work-free grants to support and encourage students with outstanding academic and research potential. For example, it is not uncommon for programs to offer fellowships that will increase the racial and ethnic diversity of the students in

the program. Many programs also provide some form of tuition remission. They may offer complete remission, meaning that the student pays no tuition at all, or they offer some tuition reduction (e.g., half), and cover students' health insurance fees. Alternatively, the program may allow out-of-state students to pay in-state tuition.

As we mentioned earlier, many programs, especially those at freestanding professional schools, do not offer funding to the large majority of students. One survey of APA-accredited clinical psychology doctoral programs found that approximately 6% of students entering a freestanding practice-oriented Psy.D. program were offered full financial aid, compared to 57% of students in practice-research Ph.D. programs and 84% of students in research-oriented Ph.D. programs (Norcross et al., 2004). Thus, the type of program you are seeking will likely have a large impact on your pocketbook.

The National Institutes of Health (NIH) Loan Repayment Program has added some much needed help for psychology graduates with student loan debt (Clay, 2006). This program offers different types of loan repayment options, depending on a graduate's research interests (e.g., patient-oriented research, health disparities research, pediatric research). For example, if graduates commit to working at least half time for 2 years in a NIH-relevant research-oriented position (e.g., working on nonprofit or government-subsidized research in the areas of clinical or pediatric psychology), they can receive up to $35,000 per year to repay their student loans, and students can apply for more than 1 year of this funding. This federal program is in great demand, so the funding is in no way guaranteed, but it has helped a great many research-oriented students to decrease their debt while also adding to the research knowledge needed to help clients. Clinically oriented students can seek loan repayment assistance through the National Health Service

Corps (Clay, 2006). Those who commit to working for at least 2 years in an underserved area of the United States (such as an impoverished urban area or a rural or tribal community with limited health-care services) can apply to have a significant portion of their loans repaid. The amount varies depending on the community's Health Professional Shortage Area score, but it can be as much as $50,000 for providers working full time for 2 years in a community with a high score, and those providers may be able to pay off all of their student loans if they continue their service there. This program is also in great demand because it allows successful applicants to reduce or eliminate their debt while also helping provide psychological services to individuals who might not otherwise have access to such services.

More information on the NIH Loan Repayment Program and the National Health Service Corp program can be found on the internet. Both are subject to change, so make sure to check the most up-to-date information when you are close to completing your graduate degree.

Academic and Emotional Commitments

In addition to the financial costs associated with doctoral programs in clinical psychology, you will be expected to make other commitments. For one thing, you will be asked to work harder than you likely ever have in your previous academic endeavors. In addition, given the competitiveness of clinical psychology Ph.D. programs, the majority of students will have to uproot themselves from friends and family to relocate to the school where they are accepted. Another move is likely when students are accepted for their full time internship toward the end of their graduate program, and perhaps yet another when the time comes to seek a postdoctoral fellowship or a first job.

We are not presenting this admittedly sobering information to discourage you from applying to doctoral programs in clinical psychology. Rather, we are doing so to help you better prepare for the initial decision-making process through which all potential applicants should go before they spend the hundreds of dollars and numerous hours needed to apply to graduate programs in clinical psychology. It is worth noting, too, that many prospective students are not accepted anywhere the first time around and so must go through the application process more than once. This is especially true if they are seeking admission only to the most competitive research-oriented doctoral programs.

Fortunately, and contrary to what you might have heard, your application to graduate school in clinical psychology will not be jeopardized if you decide—or are forced by circumstances—to put your education on hold for a while after completing your undergraduate studies. In fact, this academic break can enhance your application if you are able to obtain a

position in the field, either as a research assistant or as a mental health worker of some kind. Both of these options will help document your commitment to the field as well as give you valuable experience and further insight in helping to decide your future. If you cannot obtain paid research or clinical positions, try to find a volunteer position in these areas. Even volunteering to work 10 hours per week in a lab while working a regular job to pay bills can make a big difference in the competitiveness of your subsequent graduate school application. If you are located near a university, consider taking one or more graduate courses in psychology or a related discipline. This, too, will help document your commitment to the field and may help you decide whether graduate school is right for you. Although your inclination may be to take clinically related courses, graduate admissions committees will probably be more impressed if you take (and do well in) graduate courses in nonclinical areas, such as statistics, research design, or advanced seminars (e.g., learning theory or cognitive neuroscience). You might get credit for these latter courses when you enter a graduate program, though many clinical programs will require that you repeat any clinically related courses you may have taken previously because they want to expose you to their specific brand of training.

We should also mention that for many clinical psychologists, graduate school was an exciting and rewarding time. Despite the workload and relative poverty, there were riches in terms of learning, personal growth, and relationships with friends and colleagues. It is also heartening to know that graduates tend to be relatively satisfied with their jobs after they complete graduate school (see Table 16.3).

Table 16.3 Recent Ph.D. Graduates' Satisfaction with Their Current Job

Based on a large survey of students who graduated with a Ph.D. in psychology in 2009, the following numbers reflect the percentage of recent graduates who were either satisfied or very satisfied with these characteristics in their current job:

Income/salary	66.7%
Benefits	75.4%
Opportunities for promotion	62.2%
Opportunities for personal development	77.4%
Opportunities for recognition	75.2%
Supervisor	77.2%
Coworkers	84.6%
Working conditions	81.2%

Source: Data from Table 5c of the APA 2009 Doctorate Employment Survey (www.apa.org/workforce/publications/09-doc-empl/table-5abc.pdf).

Deciding whether it is worth it to you to make the sacrifices required for graduate school will depend on many factors, including your expected job satisfaction and your view of the lifestyle you anticipate once you've graduated. Financial rewards are one part of these considerations. In Chapter 1, we review some salary figures from the APA, and you can find estimates for clinical, counseling, and school psychologists at the website of the United States Bureau of Labor Statistics. While it can be somewhat misleading to

look at results when these different degrees and disciplines are grouped together, the data are nonetheless intriguing. The mean annual wage nationally for 2018 graduates is listed at $85,340, though there is considerable variability depending on the work setting and region of the country. For instance, the mean annual wage for psychologists working in elementary and secondary schools is $78,970, while it is $96,930 for those working in the offices of other health practitioners. Further, psychologists working in Vallejo-Fairfield, California have a mean annual wage of $119,110 while those working in the West Montana non-metropolitan area have a mean annual wage of $54,090.

Are My Credentials Strong Enough for Graduate School in Clinical Psychology?

In order to evaluate your credentials objectively and to be aware of your strengths and weaknesses, it is important to understand the criteria employed by graduate admissions committees in clinical psychology. These include: (a) the requisite undergraduate experiences, especially research experience and, to a lesser extent, coursework; (b) GRE scores; (c) GPA; and (d) letters of recommendation. Each graduate program may weigh these criteria differently, and programs will examine other factors (e.g., personal statements, interviews) as well, but all of these criteria tend to be used, to some extent at least, by all doctoral clinical programs.

Undergraduate Coursework and Experience

Your undergraduate years offer the opportunity not only to take courses but also to gain career-relevant experience in psychology.

Coursework. Your undergraduate department will have designed a graduate preparatory major to meet your course needs. It will probably include a core program of introductory psychology, statistics, and experimental psychology/research methods (including a laboratory experience). These are the minimum requirements for most graduate programs, regardless of specialization area. Note that a class in research methods has been identified as the most important class for students who seek training at the doctoral level in a clinical psychology Ph.D. program (Sayette & Norcross, 2018). For careers in clinically oriented fields, you also might consider taking courses such as abnormal psychology, abnormal child psychology, introduction to clinical psychology, clinical research methods, tests and measurement, and other courses that are specific to your area of interest. It is rarely necessary to take more than one or two of these basic clinical survey classes, so we encourage you to also take advanced seminars where you can learn about a topic in depth. Some programs also allow highly motivated undergraduate students with strong grades to take a graduate class as a non-degree-seeking student. All of these courses should help you come to a clearer decision as to what type of career you wish to pursue, and they can help you score higher on the Graduate Record Exam (GRE) Subject Test in Psychology if you are required to take it.

Research Experience. While standard coursework can help you determine what areas of psychology interest you most and demonstrate your

basic competence as a student, research experience is typically considered more critical for demonstrating your qualifications for conducting doctoral-level work. Independent research such as an honors thesis and experience as a research assistant (working as a volunteer, for pay, or for course credit) are very helpful, in general, and essential for entry into Ph.D. programs.

There are many reasons for gaining research experience prior to applying to doctoral programs in clinical psychology. First, the Ph.D. in clinical psychology is both a research degree and a clinical degree, and in many programs you will spend more of your graduate training on research than on clinical work. Admissions committees want to ensure that applicants understand what is involved in research and that they are excited about and committed to research activities. Second, working on several research projects will give you a deeper understanding of what research in graduate school will be like. It is not unusual for undergraduate students to sign up as research assistants simply because they know that the experience will help their application to graduate school, but then find that they truly love being involved in research. Others find that research is really not for them, and so they reconsider their plan to apply to research-oriented Ph.D. clinical programs. Third, working with faculty on their research is an excellent way to obtain letters of recommendation that define more precisely and credibly your potential for graduate school. Fourth, working on research projects can help you decide which research areas you would (and would not) like to pursue in graduate school. This information, in turn, will help you apply to those psychology departments whose faculty members are working in the areas of your greatest interest. Finally, research experience serves as an excellent basis for discussion with faculty during any graduate school interviews that you might later have as part of the application process.

Recent years have seen a trend in which an increasing number of interviewees for Ph.D. programs have undertaken an independent honors thesis or capstone research experience. Many successful applicants to research-oriented clinical programs have already presented their research at a conference (perhaps as co-author on a poster) or have been a co-author on a published research article. Such publication credentials are typically considered the most impressive and prestigious evidence of research experience because they indicate that an applicant has made extensive and conceptual contributions to work in the field. Needless to say, applicants who have no research experience are at a distinct disadvantage during the interview process, because they do not have the depth of knowledge that comes with working intensively on a specific research project.

Clinical Experience. If you think you want to be a clinician, but have never worked with a clinical population, we encourage you to consider gaining some clinical experience. Often, structured programs (e.g., suicide or crisis hotlines, or child advocacy groups such as *guardian ad litem* organizations) will provide excellent training as well as close supervision for your volunteer work. Working with clients who have psychological problems can be very demanding, and it is not for everyone. We know of a number of professors who had planned to become clinicians but changed their minds after volunteering in a clinical facility. Others found that the experience confirmed their belief that the work would be challenging and rewarding. For some people, hearing in-depth, personal stories about others' emotional pain and trauma makes it difficult for them to enjoy their own lives, and the caregiver's empathy leads to sustained sadness as they carry that emotional weight outside the clinical setting. Others are able to be empathic and emotionally connected while in the clinical setting, but can still enjoy their

lives outside the clinical setting, often drawing motivation from their clinical work to figure out new approaches to better address the problems affecting their clients. Both responses are understandable, but before applying for graduate training it is helpful to figure out how intense contact with others' emotional pain will affect you.

Although clinical experience can be valuable in helping students decide whether the mental health profession is the field for them, and in knowing which clinical areas (e.g., child, substance use) they are especially interested in, clinical experience is not typically deemed especially important by those involved in graduate program admissions. This is especially true for Ph.D. programs in clinical psychology, where members of admissions committees may see interest in and aptitude for clinical work as quite common, whereas they are looking for those relatively few applicants who have the genuine interest and requisite skills for a long research career. Undergraduate clinical experience is valued to a greater degree by admission committees selecting students for training at the master's level in psychology or social work, as well as for Psy.D., or school or counseling psychology programs, all of which put more emphasis on clinical training.

Extracurricular Activities. Participation in extracurricular activities, including psychology clubs and honor societies such as Psi Chi or Psi Beta, can help you learn about the field and come into contact with professionals from various specializations. Many psychology clubs provide talks on careers in psychology, how to prepare for the GREs, and how to apply to graduate school. Being a member of these groups will help you learn more about the field, but membership alone will not add significantly to your application for graduate school. Being in a leadership position in one of these organizations, however, will likely strengthen your application because it suggests that you

have initiative and leadership skills and it may also lead to a strong and detailed letter of recommendation from the organization’s faculty advisor.

Graduate Record Exam Scores

Most graduate schools use standardized tests to assist them in evaluating applicants. The most common example is the GRE, including both the General Test and, less frequently, the Psychology Subject Test. The GRE is a valid predictor of success in graduate school as measured by outcomes such as graduate GPA and publication citation counts (Kuncel & Hezlett, 2007), but there are concerns that prioritizing these tests in admission decisions makes it harder to diversify the field.

Many people worry about whether the wording or structure of GRE items might be more familiar to people of a particular gender, or racial, ethnic or other group, thus giving certain groups an advantage over others. Fortunately, research on this question has generally suggested little evidence of bias (Kuncel & Hezlett, 2007). Thus, the GRE can provide useful data to compare applicants in an objective way. Still, admissions committees typically try to view each applicant as a person who can be evaluated via multiple indicators of their potential for success in graduate school. Ideally, no single score or indicator is overemphasized.

Students often ask what GRE scores are necessary to get past the initial screenings used by admission committees. This is a difficult question because, first, programs vary considerably in the range of GRE scores they expect from their incoming students. Second, graduate programs often do not have strict GRE cutoff scores but instead employ guidelines as to what they are looking for. For example, the minimally acceptable GRE scores reported by schools in the graduate guidebooks tend to be considerably below the median scores of the entering graduate classes (Morgan & Korschgen, 2013).

In other words, if your GRE scores are just at or a little above the minimally acceptable scores reported by a school (e.g., at the 50th percentile on each subtest), you probably will not be admitted to that program. To be a strong candidate for admission to an APA-accredited Ph.D. clinical program, it would be ideal for you to score 150 or above on the quantitative and verbal scales of the revised general GRE test. That said, there is certainly variability in expected scores across schools, and students with other very strong aspects of their admissions package may not need as high GRE scores to be competitive (see Sayette & Norcross, 2018, p. 45). We discuss the GRE in more detail later in this chapter.

Grade Point Average

Whereas the GRE is seen as a predictor of certain key abilities that will be useful in graduate school, undergraduate GPA is seen as an indicator of the effort exerted in college and the ability to learn new material and to demonstrate that learning on tests and other standard academic tasks. Once again, it is impossible to offer absolute guidelines as to what Ph.D. clinical programs are looking for when they examine an applicant's undergraduate GPA. Surveys of entering classes in Ph.D. clinical programs suggest that a psychology GPA of at least 3.5 or 3.6 (on a 4-point scale) is typically necessary to be a strong candidate for admission (Sayette & Norcross, 2018). The expected GPA is usually lower for Psy.D. or less research-oriented programs. Thus, if your GPA is somewhat marginal, consider trying to improve it by repeating courses in which you did poorly. For example, if you earned a B-minus in undergraduate statistics, you would be well advised to retake the course. Otherwise, admission committees may be concerned about your ability to handle more difficult graduate statistics courses, where a B-minus is the minimum acceptable grade. Some students with marginal GPAs take additional courses after graduation (e.g., via a post-baccalaureate program) so that their application package can include grades in addition to those in their undergraduate transcript. If your overall GPA is being brought down by a particular course or poor performance in a particular semester, you should provide some context to help selection committees understand the situation (e.g., that you had a health problem that has since been resolved).

As mentioned earlier, efforts are being made by many graduate programs these days to consider students' applications as a whole, rather than

focusing heavily on any single score, such as the GPA. These efforts are aimed partly at increasing the diversity of clinical psychology graduate students by reducing the impact of potential bias in the selection process (e.g., failing to take into account the negative impact of discrimination on academic performance; see Billingsley & Hurd, 2019).

Letters of Recommendation

When reading letters of recommendation, admissions committee members tend to look for comments relating to the applicant's overall potential for graduate school, willingness to work hard and show initiative, intellectual curiosity and openness to feedback, level of interpersonal skills, ability to work collaboratively, and likelihood of success in clinical work. Letter writers are not likely to learn these things about you through classroom contacts alone. Even if you received one of the top grades in a course, if the professor had no other contact with you, there is not much else he or she can say about you. Thus, it is crucial that you develop means of interacting with faculty outside the classroom. The best way to do this is to get involved as a paid or volunteer member of one or more faculty member's research groups. In addition, make a point of stopping by professors' offices to talk with them about class content that has intrigued you. Most professors welcome these visits!

Ideally, your professors should be able to write about your motivation, your conscientiousness, your ability to think intelligently about the subject matter, your ability to take on independent responsibility, and your maturity, among other factors. You need to give them enough samples of your behavior in these domains that they can write a positive and knowledgeable letter. If you plan to take some time away from school before applying for graduate study be sure to maintain some contact with the professors from whom you plan to ask for letters. Simply sending them an update on your work and plans a couple of times each year helps these potential letter writers to stay

connected to your professional development and remember all the great work you did when you worked with them.

Given My Credentials, to What Type of Program Can I Realistically Aspire?

One of the most difficult things about applying to graduate school is being realistic about the strength of your credentials. They may simply not be strong enough to gain entry to Ph.D. programs in clinical psychology. These programs routinely receive anywhere from 100 to 400 applications and generally accept anywhere from 3 to 15 students. Thus, as already mentioned, these programs are extremely competitive and shortcomings in any of the selection criteria described above can undermine your chances of being accepted. Unless you are willing to apply more than once (and take time between applications to gain experience to improve your competitiveness), you may be setting yourself up for disappointment.

Several other options are available. For example, the GPA and GRE expectations of master’s programs in clinical psychology are usually lower than those of Ph.D. programs. You might want to consider these programs if a terminal master’s degree will allow you to meet your career goals. But be cautious about entering a clinically oriented master’s program as the first step toward a Ph.D. program. It can be a reasonable path if it addresses your need to compensate for a low undergraduate GPA, but it is typically a very expensive route to the Ph.D., because many doctoral programs do not allow students to transfer many (or any) of the credits they received elsewhere. So having the master’s degree may not shorten the length of your doctoral program. Further, if the master’s program you complete did not provide any high-quality research experiences, it may not do much to strengthen your credentials. So although master’s programs in clinical psychology can often

be valuable, be aware of what they can and cannot provide. Their clinical training can vary in quality and rigor, so it is important to evaluate prospective programs carefully. Before applying, do your homework to evaluate markers such as what the programs' students typically do after graduation, typical class sizes, and the extent to which each program emphasizes training in research-supported assessments and therapy.

Counseling psychology, school psychology, and social work programs that offer clinical training also tend to be less competitive than Ph.D. programs in clinical psychology. As noted earlier, students in these programs often receive as much applied training and experience as students in clinical psychology programs, and master's-level job openings, and even potential licensure, appear to be on the rise. Finally, nonclinical Ph.D. programs in psychology (e.g., developmental, social) tend to attract fewer applicants and have lower admission criteria than do clinical programs. If you are committed to the field of psychology and want to remain in a research environment, you may find a nonclinical psychology Ph.D. program more rewarding than a mental health-related doctoral or master's program in another field. Further, completing a research-oriented, nonclinical master's program can help increase your research experience and productivity, and thus strengthen a subsequent application for a clinical Ph.D. program.

In short, Ph.D. programs in clinical psychology often provide great training but they are not for everyone. They are highly competitive, they place great demands on their students, they take 6 to 9 years to complete, and they emphasize research training as much as, if not more than, clinical experience. But if a Ph.D. in clinical psychology is truly what you want, please read on.

I Have Decided to Apply to Graduate School in Clinical Psychology. What Should I Do Now?

Applying to graduate school is a major step that requires considerable planning. Here we list the main tasks you will have to complete. Later, we provide more information on how to accomplish them.

1. Study for and take the GRE General and Subject tests at least once each.

2. Search online for training programs, and identify at least 10 to 15 that appear appropriate for you and your interests.

3. Obtain information on these programs, and fill out the application and relevant financial aid forms for each.

4. Arrange for your transcripts from all of your undergraduate institutions to be sent to each graduate program.

5. Arrange for your GRE scores to be sent to each program.

6. Identify three or four professors who are willing to write letters of recommendation for you, and give them the necessary forms and information about your undergraduate career at least one month prior to the first application deadline.

7. Write a general personal statement and revise it as often as necessary based on feedback you have received from one or more faculty members and current graduate students.

8. Individualize your general personal statement for each program to which you are applying so the statement clearly shows your fit for that program and,

in particular, your fit for a given professor’s research lab. This last step is both crucial and time-consuming because it involves learning enough about the research of at least one professor at each site that you can note your interest in that research topic in a compelling way.

9. Once you have submitted your applications, check with each department to which you have applied to ensure that your application is complete. The large majority of admissions offices now have online tracking systems that allow applicants to verify the status of their applications, and although some departments notify students when letters of reference or GRE scores are missing, many do not. To eliminate this problem, be sure to track your application through the proper channels at the different programs.

How Do I Get Information About Graduate Programs and Identify "Good" Ones?

The first step in choosing a graduate program is to be sure it will provide the training and professional environment that will meet your needs as determined by your personal goals and plans. Are you most interested in research, balanced training in clinical practice and research, or primarily in clinical practice? Are you interested in doctoral-level or master's level programs? Do you have an interest in a specific client population? These are but a few of the questions you should be asking yourself before the application process begins. The stronger your credentials, the more freedom you will have in deciding to which programs you will apply.

Unlike professions such as law, psychology maintains no widely accepted list of top-ranked programs. To determine whether a particular university, department, and program fits your needs, including whether it offers the mix of "research" versus "clinical" that is right for you, you should gather as much information as possible, not only through the channels described below but also by corresponding with some of the graduate students and faculty in each program. Be sure to learn about whether there are faculty undertaking research in areas of interest to you, and whether those faculty plan to accept a new doctoral student in the coming year (check the faculty listings on department websites, or email professors directly). What are the graduation and internship placement and licensure rates? What types of jobs do students typically take after graduation? What is the student–faculty ratio? Are there opportunities for a variety of practicum experiences? What are the campus and local communities like? Are potential

research advisors supportive and welcoming? How extensive and adequate are the department’s research and other resources? What theoretical orientation(s) or approaches are emphasized by the program’s clinical faculty?

Admittedly, some of these questions are difficult to answer without making a visit or talking frankly with current students, so ask your research advisor or some other trusted faculty member in your department for recommendations and candid feedback on your list of potential graduate schools. Similarly, graduate students in your department know a great deal about the application process—they have all been through it. If you have clinical psychology graduate students as teaching assistants or instructors, talk with them about their application experiences. They may also have information about programs that you are interested in because they may have also applied to and been interviewed at those programs not long ago.

If you can attend one or more regional or national psychology conferences, make it a point to approach graduate students who currently attend Ph.D. programs to which you’re considering applying and ask them about what life is like in those programs. You can often talk to these students when they are presenting posters at conferences; this is also a great chance to learn more about the research going on in the program.

Dr. Arthur Evans, Chief Executive Officer of the American Psychological Association since 2017, leads the country's largest organization of doctoral psychologists and graduate student trainees.

(Source: With permission of APA Publishing.)

Table 16.4 shows a number of valuable resources that can help in all stages of the application process. We highlight three of them here because they are especially useful. The first is *Graduate Study in Psychology* (American Psychological Association, 2018h), which lists all master's and doctoral programs in the United States and Canada. This book delineates which programs are APA- or CPA-accredited, and also lists programs in other areas of psychology (industrial/organizational, behavioral neuroscience, cognitive, etc.). The APA offers an online version of *Graduate Study in*

Psychology that includes a searchable database. The cost is approximately $20 for three months of access: www.apa.org/pubs/databases/gradstudy/index.aspx.

Table 16.4 Helpful Resources for Psychology Majors and Those Who Are Considering Applying to Graduate School

This is not an exhaustive list, but many of these books have been extremely helpful to students who are considering a career in psychology and who plan to apply to graduate school.

Career Options in Psychology	**Applying to Graduate School**
Careers in Psychology: Opportunities in a Changing World, 5th ed., by Tara L. Kuther and Robert D. Morgan (Thousand Oaks, CA: Sage, 2019)	*Applying to Graduate School in Psychology: Advice From Successful Students and Prominent Psychologists*, by A. C. Kracen and I. J. Wallace (Washington, DC: American Psychological Association, 2008)
Finding Jobs With a Psychology Bachelor's Degree: Expert Advice for Launching Your Career, by R. E. Landrum (Washington, DC: American Psychological Association, 2009)	*Getting In: A Step-by-Step Plan for Gaining Admission to Graduate School in Psychology*, 2nd ed., by the American Psychological Association (Washington, DC: American Psychological Association, 2007)
The Insider's Guide to the Psychology Major: Everything You Need to Know About the Degree and Profession, by A. R. Wegenek and W. Buskist (Washington, DC: American Psychological Association, 2010)	*Graduate Study in Psychology*, by the American Psychological Association (Washington, DC: American Psychological Association, 2018)
The Portable Mentor: Expert Guide to a Successful Career in Psychology	*Insider's Guide to Graduate*

(2nd ed.), by M. J. Prinstein (New York: Springer, 2013)

The Psychology Major: Career Options and Strategies for Success (5th ed.), by R. E. Landrum and S. F. Davis (Hoboken, NJ: Pearson, 2013)

Your Career in Psychology: Putting Your Graduate Degree To Work, by S. F. Davis, P. J. Giordano, and C. A. Licht (Malden, MA: Wiley-Blackwell, 2009)

Programs in Clinical and Counseling Psychology, by Michael A. Sayette and John C. Norcross (New York: Guilford, 2018)

Surviving Graduate School and Beyond

The Compleat Academic: A Career Guide, 2nd ed., by John M. Darley, Mark P. Zanna, and Henry L. Roediger (Washington, DC: American Psychological Association, 2004)

Life after Graduate School in Psychology: Insider's Advice from New Psychologists, by Robert D. Morgan, Tara L. Kuther, and Corey J. Habben (New York: Psychology Press, 2012)

You've Earned Your Doctorate in Psychology… Now What? Securing a Job as an Academic or Professional Psychologist, by E. M. Morgan and E. Landrum (Washington, DC: American Psychological Association, 2012)

A publication similar to the print version of *Graduate Study in Psychology* is called *Getting In: A Step-by-Step Plan for Gaining Admission to Graduate School in Psychology*, 2nd ed. (American Psychological Association, 2007c). It provides detailed information on the application

process for graduate programs in any area of psychology. Many sections of the book focus on specific aspects of the application process (choosing programs, preparing a resume, writing a personal statement, etc.), and there is an appendix with a timetable for the application process.

An extraordinary resource aimed specifically at clinical or counseling doctoral programs is the *Insider's Guide to Graduate Programs in Clinical and Counseling Psychology 2018/2019 Edition* (Sayette & Norcross, 2018). This book focuses on the application process and also lists every APA- and CPA-accredited Ph.D. and Psy.D. program in the United States and Canada, with helpful information about each. The programs' orientations are rated on a 1 to 7 scale (where 1 means fully practice oriented, 4 means equal emphasis on practice and research, and 7 means fully research oriented).

Additional information can be found online, including at the APA website (www.apa.org), where you can explore APA-accredited programs, careers in psychology, and salary information about various jobs in psychology. The Council of University Directors of Clinical Psychology (CUDCP) also maintains a website that provides excellent information about applying to clinical doctoral programs: http://clinicalpsychgradschool.org/. The site includes advice about whether to pursue a clinical Ph.D., guides to choosing programs that will be a good fit, many application tools and tips, as well as links to labs and programs hiring for post-baccalaureate positions. CUDCP also supports an online calendar that lists the application deadlines and interview dates for some programs: https://teamup.com/ks952632ef38687f3e. The link to additional resources (http://clinicalpsychgradschool.org/resou.php) includes advice on applying, links to organizations with additional tips, directories of programs, and numerous other helpful resources.

In an effort to help students learn more about programs as they decide where to apply, CUDCP also has a voluntary program through which clinical programs provide full disclosure of admissions and outcome data for their program on their website. This information is very useful to potential applicants, who can then compare programs directly on the same variables, including number of applicants, number of accepted students, number of underrepresented students in the program, GRE and GPA averages for recently admitted students, number of graduate students who applied for and secured an internship, number of graduating students and their job placements, and average length of time it took for those students to graduate. If you are scanning doctoral programs online, go to the clinical psychology website for a department that interests you and look for this Full Disclosure Data page.

You can also find related information at a department's clinical area website under "Student Admissions, Outcomes, and Other Data." This link will take you to tables containing program data from the past 10 years that the APA requires all APA-accredited doctoral programs to update annually. There you can review the following information:

- Time it takes to complete the program.
- Cost of completing the program (e.g., tuition, fees, financial aid options, etc.).
- Percent of incoming students receiving funding.
- Success of graduate students in obtaining internships.
- Attrition (i.e., how many students enter the program and then drop out each year).

- Number and percentage of graduates from the program who have become licensed in the past decade.

This information is meant to help students compare programs on these variables so that they can make informed decisions when considering their options for graduate training (Munsey, 2007). For example, as noted in Chapter 15, there has been a nationwide "internship imbalance" that leaves some students without access to an internship site (McCutcheon, 2011). While this imbalance has been alleviated to some extent by the addition of more internship programs, the problem remains for students in certain training programs (Parent & Williamson, 2010), so be sure to look carefully at the internship "match" rates of all the programs you are considering. Be aware, for example, that a comparison of APA-accredited clinical psychology programs found that freestanding Psy.D. programs had significantly lower internship match rates than any other type of program (Norcross, Ellis, & Sayette, 2010). When searching clinical programs' websites, look for the link to "Student Admissions, Outcomes, and Other Data" to find the internship match information.

There is also an impressive blog called "How to apply to clinical psychology Ph.D. programs: Practical advice from someone who's done it … three times." by Emily Bell. She was a graduate student in clinical psychology at Kent State University and a valuable aspect of her blog is its acknowledgment that it often takes multiple tries to get into a Ph.D. program in clinical psychology (http://clinicalpsychgradapp.wordpress.com/).

There are also online message boards for students interested in clinical psychology (Fauber, 2006). Sites such as *The Student Doctor Network* (http://studentdoctor.net/) in clinical psychology receive a great deal of

attention from prospective students. Given that the postings are mostly just other students' opinions, you may want to check more formal sites to confirm information that is crucial to your application (e.g., an application deadline or specific information about a professor), but message boards are yet another way that you can have access to up-to-date information.

With the wealth of information in printed material as well as online, you should have plenty of resources available during the arduous task of applying to graduate school. But beware. Many websites are run or funded largely by for-profit institutions—so seek information from reputable sources that are not trying to sell you something, and think critically about the information you find. Also, be cautious about overinterpreting information on listservs or sites where prospective applicants share information about interview invitations or admissions offers. While this information can be valuable, it can also be misleading. For instance, an applicant hoping for an on-campus interview might assume that he will not be invited because someone else posted that she had already received an invitation. But not all invitations go out at the same time, so the lack of an invitation may mean nothing about one's interview prospects.

Another resource for identifying potentially good programs is the U.S. News and World Report's ranking of the "Best Clinical Psychology Doctorate Programs," It was last updated in 2016: https://www.usnews.com/best-graduate-schools/top-health-schools/clinical-psychology-rankings. While these rankings can be helpful for getting a general sense of a program's standing, there is wide skepticism in the field about their validity—even among faculty who work at the top-ranked programs. There is a strong sense that the rankings are not necessarily based on the most important criteria. Thus, we alert you to this site because you

may hear about it in your search process, but you should view its information cautiously and in a general, rather than very specific, way. For instance, knowing that a program is among the top 25 programs likely is a useful indicator that it is a high-quality program, but knowing a program is in 7th place versus 12th place likely does not provide useful distinguishing information. Determining the right program fit for *you*, especially with regard to making a match with a good faculty research mentor, is far more likely to influence your ultimate happiness with your program choice.

Professional journals and related publications are additional information sources that many applicants overlook. For example, one of the best ways to find programs that meet your needs is to identify faculty who are studying topics that interest you. A thorough search of the literature—using PsycINFO, Google, Scholar, or other online search engines—will likely highlight faculty with whom you might like to study and indicate where they can be reached. A related approach is to pay attention to the journal articles you've read in your classes or research projects that particularly fascinated you, identify the authors and their departments, and then look for their personal websites and/or curriculum vitae (CVs). Their email addresses are nearly always posted on the university website (check the "People" section for the Psychology Department); email addresses are also listed on professors' published articles. However, do some homework before asking these people questions about their work or the graduate program that could easily be answered with a quick review of their CV or the departmental website.

Regardless of how you identify the faculty members who could be your future research advisor, do not rush this part of the process. We cannot

overstate the importance of making a good match with a research advisor; it is crucial to success in a doctoral program.

What Does It Mean When a Clinical Psychology Graduate Program is Accredited by the American Psychological Association?

American Psychological Association (APA) accreditation means that a clinical program has met a minimum standard of quality (see Chapter 15). Accreditation applies to educational institutions and programs, not to individuals. It does not guarantee jobs or licensure for individuals, though being a graduate of an accredited program greatly facilitates such achievements. It does speak to the manner and quality by which an educational institution or program conducts its business. It speaks to a sense of public trust, as well as professional quality.

Thus, graduating with a Ph.D. from any APA-accredited program is seen as a laudatory accomplishment. Further, some APA-approved internships will only accept applicants from APA-approved graduate programs and many states will only grant licensure as a psychologist to applicants from an APA-accredited program. These are all reasons to consider limiting your search to APA-accredited programs, though be aware that, as we mention in Chapter 15, there is now an alternate program accreditation option, namely, the Psychological Clinical Science Accreditation System (PCSAS; see below). As a result, a number of top research-oriented programs are accredited by both APA and PCSAS. Further, some top doctoral programs may not maintain their APA accreditation in the future, and thus may be accredited only by PCSAS. This change will probably be noted on each department's website so applicants can make informed choices about where to apply. Overall, then, we recommend selecting an accredited program. Both APA and PCSAS accreditation are good markers of quality, but may have different

implications for flexibility in obtaining a psychology license. In some states, only applicants from APA-accredited clinical programs are currently eligible for licensure.

A list of APA-accredited programs in clinical psychology is published each year in the December issue of the APA's main journal, *American Psychologist*. The APA also accredits Ph.D. programs in other areas, including counseling and school psychology, as well as a number of Psy.D. programs. Master's programs are not currently accredited by APA, so it is more difficult to identify high-quality programs at that level, but APA is exploring whether to accredit master's programs in the future—yet another example of the interesting transitions happening in the field.

A complete list of APA-accredited programs in clinical, counseling, and school psychology can be found on the APA website at www.apa.org/ed/accreditation/programs/clinical.aspx

What Does it Mean When a Clinical Psychology Graduate Program is Accredited by the Psychological Clinical Science Accreditation System?

As mentioned in Chapter 15, the new Psychological Clinical Science Accreditation System (PCSAS) was developed by research-oriented clinical scientists who were dissatisfied with the APA accreditation system (Baker, McFall, & Shoham, 2008). PCSAS set out to develop an accreditation system that focuses on programs that strongly emphasize the *science* of clinical psychology, and they base accreditation criteria mainly on whether the programs' graduates later work as clinical scientists (e.g., conducting research or otherwise advancing clinical scientific knowledge), rather than whether the programs include particular kinds of coursework or practicum requirements. Both accreditation systems value and expect high-quality research and applied clinical training, but they vary in some of their requirements and in their emphasis on empirical rigor.

The first clinical psychology program was accredited by PCSAS in 2009, and by 2019, 39 programs had been accredited and 7 more were under consideration. The latest list of PCSAS-accredited programs is available at https://www.pcsas.org/accreditation/accredited-programs. As of 2020, all PCSAS-accredited programs are also accredited by APA but, as mentioned above, some of them may not be renewing their APA accreditation, so if you are interested in one of these programs, be sure to ask about the implications of these changes. There is a helpful Frequently Asked Questions section on the PCSAS website (https://www.pcsas.org/faq/) that provides up-to-date information about relevant internship and licensing regulations for PCSAS students and graduates.

When Should I Apply, and What Kind of Timeline Should I Expect?

Specific timelines can be found in both *Getting In: A Step-by-Step Plan for Gaining Admission to Graduate School in Psychology*, 2nd ed. (American Psychological Association, 2007c) and the *Insider's Guide to Graduate Programs in Clinical and Counseling Psychology* 2018/2019 (Sayette & Norcross, 2018). These guidelines should help to make sure you are accomplishing all of the necessary application tasks in a timely fashion.

In general, it is reasonable to start seeking program-specific information in June or July, a little over a year before your desired admission date (e.g., July 2021 for the fall of 2022). Seeking specific information earlier than this can sometimes backfire, because admissions deadlines or requirements might change from year to year, but it is never too early to look for more general information about programs that fit your needs because overall program emphases and training philosophies do not usually change that rapidly. In any case, nearly all graduate programs post admissions information on their websites, most programs also post application forms and related materials, and many have a Frequently Asked Questions section that helps to clarify the application process.

Although department application deadlines vary, most fall between December 1 and January 15. A few come earlier, while others (mostly for master's degree programs or professional schools) are later. Some departments with later deadlines select their students continuously as applications arrive for processing. If you apply to programs that use this "rolling admissions" plan, it is to your advantage to submit your application early.

Our comments here refer specifically to the timeline of the application process; preparing yourself to be a strong applicant for graduate school should begin much earlier, because multiple years of research experience have become the norm for competitive applicants.

To How Many Programs Should I Apply?

It is difficult to identify a specific number of applications that is appropriate for all students. We are reminded of two cases: One student applied to six schools and was admitted to all of them, while another applied to 27 and was admitted to one. Because competition for admission to Ph.D. programs is fierce, the general rule is to apply to approximately 12 to 15 programs if you can reasonably afford to do so. It is not a simple matter of “more is better,” however. You should apply only to programs for which you are likely to be a good fit, based on your research background and current interests. It will make little difference whether you apply to 5 schools or 20 if you have no research background. And if your goal is to study the genetics of dissociative identity disorder, there is no point applying to programs whose faculty have no expertise in that area.

It is our experience that even students with relatively strong credentials will want to apply to at least 10 programs to increase the likelihood of at least one offer of acceptance and to increase their chances of receiving funding as well. A good rule is to apply to at least five programs which you might consider “safe” schools where your credentials would be considered to be strong, five “ambitious” programs where your credentials might not be as strong as needed but at least you are in the ball park, and a couple “stretch” programs where your credentials are below the average but perhaps where your research interests are especially well matched to those of program faculty (Sayette & Norcross, 2018). Note, however, that the demand for Ph.D. programs in clinical psychology is such that there are fewer and fewer programs that can be considered “safe” bets for admission.

As you try to categorize programs as “safe,” “ambitious,” and “stretch,” pay attention to the information about how many applications each program receives and how many applicants are admitted to the program. Even among excellent clinical doctoral programs, the percentage of admissions varies significantly, thus affecting your chances of being accepted. For example, in a recent admissions cycle, 73 students applied to the clinical Ph.D. program at the University of South Dakota and 12 (19.0%) were offered admission (2017–2018 data), while 244 students applied to the University of Virginia and 5 (2.0%) were admitted (2018–2019 data). Both programs are excellent —yet the numbers of applicants varied dramatically.

Although we know of no formal studies on this issue, it appears that programs in larger cities or especially desirable places to live (e.g., those with mild winters!) tend to receive more applications than comparable programs in smaller towns or in areas with harsher climates (remarkably, we know of at least one such program that received about 700 applications in one recent year!). Thus, if your dream school is in a highly desirable city with perfect weather, you may want to consider also looking into equally excellent programs in less popular places because there may well be fewer applicants there.

The bottom line is that getting into any clinical doctoral program is challenging but you should apply to the programs for which you fit best and where you will feel passionate about the research you would be able to do and the training you would receive.

Once you have decided on a final list of schools, ask yourself what you will do if you are not accepted by any of them. You may want to take a couple of years to strengthen your next application (such as by working in a research lab). Alternatively, if you know your credentials are marginal (e.g., a

weak GPA) when you first apply for doctoral training, consider also applying to a handful of research-oriented master's programs as a backup. However, do not apply to programs that are really not of interest to you. Such applications waste admission committee time and your time, not to mention your money.

How Much Will It Cost to Apply?

Applying to graduate school is, indeed, an expensive process. Taking both the GRE General and Subject tests costs approximately $310. Departmental application fees can be as high as $100, but average about $50 for doctoral programs and $35 for master's programs (Sayette & Norcross, 2018). Undergraduate transcripts cost about $5 to $10 each. The cost of sending GRE scores to four graduate schools is covered by the GRE registration fee, but sending them to additional schools costs $27 each. So the average cost of applying to 12 graduate programs is about $1,250. Note, too, that if you are lucky enough to be invited for an interview, you will typically also need to cover most of your travel costs.

If you are operating under significant financial constraints, there may be ways to reduce your costs. For example, the Educational Testing Service offers a GRE Fee Reduction Program for those who: (a) can demonstrate financial need (e.g., students who receive financial aid at their university and who receive little or no money from their parents); (b) are involved in certain national programs that work with underrepresented groups (such as the McNair Scholars Program or the Gates Millennium Scholars Program); and (c) are unemployed and receiving unemployment compensation (see eligibility information at https://www.ets.org/gre/institutions/advising/fee_reduction?WT.ac=40361_owt33_180820). Under this program, GRE fees can be reduced by 50%, but thorough documentation must be provided and the reductions are awarded on a first-come, first-served basis.

In addition, many universities allow you to petition for a reduced or waived application fee. Typically, one’s financial hardship must be documented, and in some cases only applicants with certain characteristics (e.g., members of an underrepresented racial/ethnic group, first generation students, or those with specific financial aid requirements) are eligible for a reduced or waived fee.

What Testing is Involved in Applying to Graduate School?

The large majority of graduate schools require the GRE for admission and most admissions committees weigh GRE scores heavily in their acceptance decisions (Sayette & Norcross, 2018), though exactly how heavily can vary considerably. Let’s review the contents of the GRE, how to study for it, and the role it plays in the graduate school admissions process.

What is the GRE?

The GRE consists of a general test and a subject test—in this case, the subject is psychology.

The General Test is described thoroughly at the Educational Testing Service's *Graduate Record Examinations* website (http://www.ets.org/gre). The General GRE Test is now called the *GRE Revised General Test* due to the new scoring procedures we describe later, and has three main components: Verbal Reasoning, Quantitative Reasoning, and Analytical Writing. The test takes about 3 hours and 45 minutes to complete and is offered via computer in the United States and most industrialized countries. There are hundreds of official testing sites across the United States and Canada, and students can arrange to take the test at a time that is convenient for them. For details on test registration, test day logistics, and score reporting, see the GRE Information Bulletin at http://www.ets.org/s/gre/pdf/gre_info_bulletin_18_19.pdf.

The General GRE Test cost is approximately $160 and your scores are valid for 5 years. The computerized testing format was revised significantly in 2011. Previously, you could see only one question at a time and had to answer that question before being allowed to proceed. The new multi-stage test allows you to skip questions and return to them later. Further, before 2011, scores on the Verbal and Quantitative Reasoning sections could range from 200 to 800 in 10-point increments. These scores can now range from 130–170 in 1-point increments. Scores on the Analytical Writing section of the revised test range from 0 to 6, in half-point increments. The test is given in six sections with a 10-minute break in the middle.

The Subject Test in Psychology is required by approximately two-thirds of doctoral programs in psychology. It consists of about 205 multiple-choice questions and takes almost three hours to complete. It costs approximately $150, a fee that includes some free preparation and support materials, such as the GRE Psychology Test Practice Book. This book includes a full-length practice test, as well as advice on test-taking strategies (see http://www.ets.org/s/gre/pdf/practice_book_psych.pdf). The test covers material from many subfields of psychology, including but not limited to: learning, memory, and behavioral neuroscience, social, clinical, abnormal, developmental, personality, and industrial/organizational psychology, research methodology, measurement, and the history of psychology. The test results in six subscale scores: (a) biological, (b) cognitive, (c) social, (d) developmental, (e) clinical, and (f) measurement, methodology, and other.

Unlike the GRE Revised General Test, the Subject Test in Psychology can be taken only on paper, and is offered only three times a year (usually in September, October, and April). It takes approximately 5 weeks to receive a copy of the Subject Test score, so be sure to take this test on a date that is at least 6 weeks before your earliest application deadline.

It is important to know the results of your GRE General and Subject Tests before you begin the graduate school application process because the scores will shape your decisions about where to apply. If you score at the 95th percentile it will be reasonable to apply to the most competitive schools, whereas scores at the 50th percentile would require a more conservative strategy. If you take the GRE tests more than once, there is a program called "ScoreSelect" (see https://www.ets.org/gre/revised_general/about/scoreselect/) that allows you to decide whether to submit all or only some of your scores for applications you

submit for the next 5 years. Be aware, though, that certain graduate programs require applicants to report scores from all of their GREs, so Score-Select may not always be an option.

Should I Study for the GRE?

Yes, you definitely should study for the GRE! The GRE website and the free preparation book mentioned earlier describes the types of questions found on the general test, along with a number of strategies you can use in taking the computer-based test. The Educational Testing Service also sells practice material, including GRE general tests and GRE subject tests actually administered in previous years. In addition, ETS now sells software that allows you to practice the computer version of the test and receive feedback on your performance. All of this material can help you become familiar with the types and forms of questions you are likely to encounter on the GRE, and it can also give you practice at pacing yourself during the actual examination.

You can also prepare for the GRE general test via test preparation courses that are presented live or online by companies such as Kaplan and Princeton Review, and also via annually revised test preparation books. Because in-person and online courses can be quite expensive (some cost more than $1,200), most students tend to use the test preparation books. These books usually provide a mathematics and vocabulary review, tips on test taking, and a set of sample test items, and many of them come with computer-based enhancement features. Some of the more frequently used "how to prepare" books are published by Barron's Educational Series, Arco Publishing Company, Kaplan, and Princeton Review. They are readily available at most online and local bookstores.

Deciding on test preparation courses versus self-preparation is a matter of individual choice and financial means. Some students do not have the time or inclination to design a disciplined self-preparation study schedule and, for

them, the expense of test preparation courses is feasible and worth it because the courses provide needed structure. An alternative strategy is to self-prepare for the first time you take the test, and then if you are not satisfied with your scores, try a formal test preparation course. Whatever you decide, some form of preparation for the GRE General Test is important. The stakes are rather high; whether you are accepted into a Ph.D. program and/or whether you receive financial aid may depend in part on how well you do on the GRE tests.

When preparing for the GRE Subject Test in Psychology, remember that it covers all areas of the discipline. Names, theories, and definitions are likely to be tested, as will basic concepts. If you have not been exposed to certain aspects of psychology, you will no doubt have trouble with some questions. You can prepare for the Subject Test by thoroughly reviewing a comprehensive introductory psychology textbook. In addition, books that present the history of psychology and/or systems and theories in psychology provide information that is particularly useful in preparing for this test. As with the General GRE, there are also online and printed materials that can help you prepare for the GRE Subject Test. If you are not a psychology major, scoring well on the GRE Subject Test may be especially important (though this will depend on where you are applying), because it may be the only way for you to show your knowledge of the field. In our experience, the GRE General test is typically weighted more than the Subject Test in making admissions decisions, but it is in your best interest to study intensively for both tests.

Why is the GRE so important to admission committees? In addition to its predictive validity, it represents the only data for which direct comparisons can be made across all applicants. Everyone takes exactly the same test, so

performance is not influenced by differences in collegiate standards, as can be the case with letters of recommendation and college grades. A score at the 85th percentile on the verbal subtest means the same whether it was earned by a student at the University of California–San Diego or at the University of Vermont. Thus, the GRE is widely viewed as providing a useful, albeit imperfect, indicator of a student's potential for success in graduate school. In addition, the GRE and undergraduate GPA together can serve as relatively objective screening instruments that help admission committees reduce several hundred applicants to a more manageable number. With this dramatically smaller pool of applicants, the admissions committee can then give much closer scrutiny to other, more qualitative and time-consuming selection criteria, such as personal statements, letters of recommendation, and personal interviews (Morgan & Korschgen, 2013).

What counts as acceptable GRE scores can vary according to the type of program to which you are applying. For example, some freestanding, non–university-based Psy.D. programs do not even require the GRE test as part of the admissions process. Acceptable GRE scores for a master's program will likely not be as high as those needed for a doctoral program. There are not yet enough data from the revised GRE scoring system to make comparisons but, to give you a general idea, one survey of scores on the old system found that students in master's programs averaged 1053 on the GRE (Verbal and Quantitative Reasoning combined), whereas students in doctoral programs averaged 1183 (Norcross, Karpiak, & Santoro, 2005). Note, however, that this survey included all areas of psychology and also included both Psy.D. and Ph.D. doctoral programs. A follow-up to that study, still using the old GRE scoring system, found that across all clinical programs, the average combined score was 1243. The highest average combined score

(1283) was found among students in research-oriented Ph.D. programs and the lowest average combined score (1061) was seen among students in freestanding Psy.D. programs (Norcross, Ellis, & Sayette, 2010). Overall, the minimum GRE scores reported for Psy.D. programs are lower than in programs with equal emphasis on research and practice, and also lower than in research-oriented Ph.D. programs (see Sayette & Norcross, 2018, p. 44, but be aware that these data are not very recent).

How Important is My Grade Point Average?

Your GPA is seen as an excellent indicator of the effort you have exerted in college and your willingness to work up to or beyond your predicted potential. Thus, an outstanding undergraduate GPA may offset to some degree a less than stellar GRE score.

Admissions committees look for several things when examining an applicant's undergraduate transcripts. The overall GPA is important, but committees often focus extra attention on your psychology GPA given its relevance to graduate study in the field. This means that committees tend to be somewhat forgiving of a lower overall GPA if, for example, you started off in another area of study (e.g., as a premed student) and did poorly in those courses. They tend to be more forgiving of poor grades early in your college career than they are of poor grades later on. They also check on whether you maintained or improved your GPA as you went along or let your grades slip as you got closer to graduation. They may pay particularly close attention to grades in more rigorous required courses, such as statistics and experimental methods, which serve as the foundation for advanced work in the field.

Will I Need Letters of Recommendation? If so, How Many and from Whom?

Three letters of recommendation are required by most graduate programs in clinical psychology. Sometimes additional letters are accepted, but we do not recommend submitting more than four unless they are requested specifically. Whether you submit three letters or four, at least two of them should be from academic references—that is, from psychology or other faculty members who are familiar with your academic ability. Ideally, at least one of the letters should be from someone who has supervised you in research-related activities. If faculty from disciplines other than psychology can enlarge the picture of your academic achievement and potential for graduate study, feel free to ask those people for letters. Applicants who gained post-baccalaureate research experience in a psychiatry or neurology department at a medical center/hospital will want to obtain letters from the faculty with whom they worked.

A letter from someone who supervised a clinically related experience or relevant job is generally not given as much weight by admissions committees at Ph.D. programs as letters attesting to research and academic skills. Similarly, letters from “important people,” such as politicians or religious leaders are unlikely to help your application unless the writer had been in a position to judge your potential as a graduate student, researcher, or a clinician. Similarly, if you know a clinical psychologist through social contacts only (e.g., as a friend of the family), you should not ask that person to write you a letter of recommendation. Although the psychologist knows what it takes to excel in graduate school, the letter will not be considered

objective because of the personal and social relationships that exist between the psychologist, you, and your family. Most letters of recommendation include a statement as to how the letter writer knows the applicant, and admissions committees do not look kindly on letters that say things like “I have known the applicant for all of her life, and I have watched her grow from a timid toddler into a scintillating senior student.”

What Should I Know About Asking for Letters of Recommendation?

When you approach faculty members to ask for a letter, it is likely that they will want you to provide information about yourself as a reminder of what role you played on a research project, what grade you got in a course, the topic of your final paper in a seminar, what honors you won, and the like. Information about your activities, accomplishments, and job experiences can supplement classroom contacts in a way that enhances the tone and thrust of a recommendation letter.

You can provide this information in the form of your résumé or curriculum vitae and a draft of your personal statement, along with a description of your research experiences (including comments about the full extent of your roles), and a brief outline of your professional goals. Some faculty may also want a list of the psychology laboratory courses you have taken or a transcript of your college courses and grades, with information about what your major (and minor, if relevant) was, and your GPA. Providing information about honor societies, clubs, and organizations to which you belong(ed), along with comments on your participation (be sure to mention positions of responsibility you held), can also be useful, as can a brief note about jobs you have held and volunteer work you have done (see Morgan & Korschgen, 2013). Some students carry heavy workloads while being enrolled as full-time students in order to pay for their education; this information should be included, too. No matter how much information you have provided, remember to ask your letter writers about any additional items they might want to see.

Be sure to ask for letters and provide all appropriate recommendation information at least one month before the first application is due. Remember, faculty often write letters for many students, so give them plenty of time to prepare yours. To reduce the possibility of error and to speed the process, do everything you can to minimize the work the faculty has to do in putting your recommendation materials together. Provide your letter writers with a list of the schools to which you are applying, along with the application deadline for each, which specific program you are applying to (e.g., master's in counseling, Ph.D. program in clinical psychology), any additional rating forms to be completed, and information about how the letter should be sent (e.g., a hard copy directly to the admission's office, a hard copy in a sealed and signed envelope to be returned to you, or perhaps an email sent to someone or posted to a secure website). If hard copies are required, then you should provide stamped, addressed envelopes for each program. Most programs these days use one of two different application systems:

1. A self-contained application, whereby the applicant has to collect all of the materials (including the letters of recommendation in a sealed envelope signed across the flap by the letter writer) and submit them in one packet, or

2. Completely online (including letters of recommendation that are either sent via email or posted to a secure website in the admissions office). This system is rapidly becoming the standard one.

Will I Be Able to See My Letters of Recommendation?

Because of federal law, letters of reference are not confidential unless you waive your right to see them. We encourage you to do so because many admissions committee members feel that letter writers are more likely to provide candid evaluations when they know that the student will not see the letter. If you are concerned about what the letter might include, ask potential letter writers if they can write *in support* of your application, not just if they will write a letter of reference. Most faculty are more than willing to say whether they can write a favorable letter for you.

What Should I Include in My Personal Statement?

Most applications require some form of a personal statement, usually 1.5 to 2 pages in length. Longer is not better because admissions committee members will be reviewing dozens to hundreds of statements and may miss important information if—as often happens—they just skim the longer ones. Good advice on writing a personal statement is provided in the two references we cited earlier: *Getting In: A Step-by-Step Plan for Gaining Admission to Graduate School in Psychology*, 2nd ed. (American Psychological Association, 2007c) and *Insider's Guide to Graduate Programs in Clinical and Counseling Psychology 2018/2019 Edition* (Sayette & Norcross, 2018).

Generally, variations on the same personal statement can be used for all of your applications, but the essay should be revised for each program to reflect how your research (and clinical) interests mesh with each particular program. Programs differ in how much weight they give to the personal statement, but it is typically pivotal in highlighting the match between you and particular research advisors and programs. It is also an important showcase for your writing skills and professionalism. Any mistakes in spelling or grammar, and any typographical errors will reflect negatively on your writing skills, your conscientiousness, and your attention to detail. Therefore, it is absolutely imperative that you ask multiple people, preferably including a current graduate student or faculty member, to read your statement for coherence and writing style as well as to identify any errors.

Contrary to its title, a personal statement should not be too personal. Think of the document as a professional rather than personal statement. It is not a general autobiography, but a chance to highlight how your earlier

experiences have prepared you and motivated you to succeed in graduate school. It is fine to share a personal story about what draws you to the field, because this can help potential advisors get to know you a bit, but make sure the focus is on your professional development and current interests relevant to graduate school.

What if your interest in clinical psychology is influenced in part by personal problems that you or your family members have had? There are pros and cons to mentioning this in your personal statement. Such problems can be hugely formative experiences in a person's life, and we certainly would not want to perpetuate the stigmatizing idea that those experiences should be hidden. Nevertheless, information about past or current problems does nothing to show your readiness to *succeed* in graduate school and, in some cases, can raise questions about your sensitivity to personal vs. professional boundaries. So whatever you decide to include, keep in mind that the main emphasis of your statement should be on what you have been doing to prepare yourself to be an excellent graduate student.

Indeed, a personal statement is akin to a job application cover letter, so similar guidelines apply. It provides you with a chance to convince the admissions committee that you are a good match for their graduate program. Think about what graduate programs are looking for in their applicants, and then describe how you meet those criteria. As noted earlier, graduate programs generally are looking for students who are intellectually curious, highly motivated, hard working, and have good familiarity with the science of psychology, especially as it relates to research experience. These are the factors that you should be addressing in some fashion in your personal statement, which should cover four key components: (a) previous research experience, (b) current research interests, (c) other relevant experience, and

(d) career goals (Bottoms & Nysse, 1999). Here, we focus on just two of them.

In the section on current research interests, make sure to include some brief discussion of how your interests coincide with ongoing research by the faculty in the program to which you are applying. This is arguably the most important part of the personal statement. Most programs assign students to faculty for research mentoring, so it should be crystal clear how your interests mesh with those of one or more of the faculty in the program. It is expected that you will name one or two faculty members with whom you would like to work and discuss how your research interests align. In fact, some programs separate applications into clusters based on which faculty members are named, and review them accordingly. That is, faculty member A will do a preliminary review of all applications that named her as the desired primary advisor, faculty member B will review those that identified him, and so on. You can name as many as three faculty members with related interests, but don't try to list the entire clinical faculty; that will make you appear unfocused and not sufficiently mature in your research interests. Listing one person is common and often effective if the person is a good match (and you have confirmed the person is accepting new students).

Ideally, you will have already made contact with at least one faculty member in each program to express interest in the person's work, so in your personal statement, mention one or two research papers from that faculty member's group that you find particularly interesting and note how the work relates to your own research interests. You are not expected to know exactly what you want to study in graduate school (your interests are likely to evolve over time), but the statement allows you to highlight the directions you are currently excited about and show that you've done your homework on each

lab. In doing so, be sure not to copy and paste information from a faculty member's web page. That faculty member probably wrote that page and seeing the same text in your personal statement may create the impression that your research about the lab has been superficial and that you are not genuinely interested in the area.

One aspect of your fit with the programs to which you are applying is compatibility of clinical theoretical orientations. As Figure 16.1 shows, the typical clinical theoretical orientations of faculty vary widely across types of programs, so it can be helpful to mention in your personal statement that your orientation would mesh well with a given program's focus. In particular, if you are applying to more research-oriented clinical programs, noting your interest in receiving training in evidence-based approaches to clinical work may be helpful.

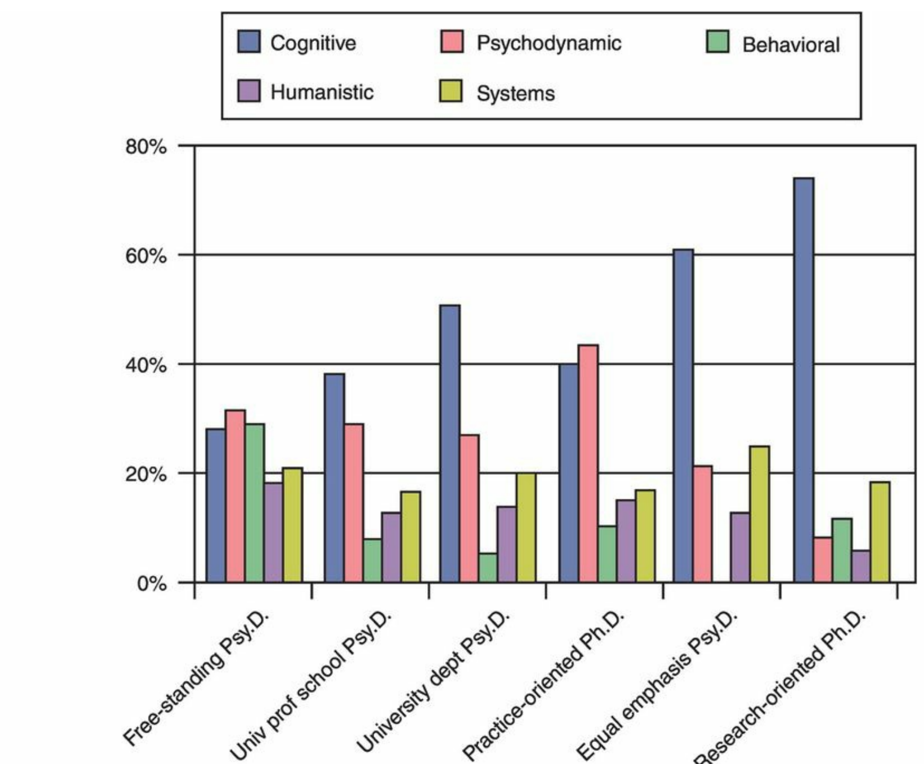

Figure 16.1 Faculty Theoretical Orientation by Type of American

Psychological Association-Accredited Clinical Program

(Source: 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*, *4*, 99–104.)

The section of your personal statement on other relevant experience is the place to include a brief discussion of any clinical volunteer work or relevant extracurricular activities in which you have been involved. Having clinical experience may not be a very important criterion for admission, but admissions committees may still like to know if you have had some experience in “helping relationships.” Similarly, a long list of extracurricular activities, such as being a member of Psi Chi, will not strengthen your application very much unless you served in a leadership role. So go ahead and include mention of clinical activities and extracurricular activities, but realize that they are not considered strongly in the admissions process except to the extent that they indicate your involvement in psychology, your interpersonal skills, and your willingness to work hard. Also, listing activities in the personal statement that are already included in your curriculum vitae adds little new information, and is usually not interesting reading.

Are Personal Interviews Required?

Once applications have been reviewed by admissions committees, it is common for strong candidates to be invited for an in-person interview. Offers for interviews usually come only after the number of candidates has been considerably narrowed down, say from 300 applicants to the 25 who are given a brief preliminary phone interview, to the 10 who will be interviewed in person. Interviews are usually held on campus to give the candidate and the department a chance to learn about potential fit on both sides. If you are invited for an interview, try to accept it if at all possible. If departments have to choose between two equally qualified students, only one of whom interviewed in person, that individual will probably have the advantage. Fairly or not, graduate admissions committees may interpret the lack of an interview as a possible sign that the applicant is not really interested in the program. Even if you cannot attend the program’s main interview days due to a conflict, you may be able to schedule an alternate visit day (though it is preferable to attend the established/invited dates). If it is financially or physically impossible for you to attend an interview, you can still show your motivation for admission to the program by requesting telephone or video-conference interviews with a number of faculty, by contacting a number of graduate students to begin a dialogue about the program, by letting the admissions committee know via email that you remain very interested in their program, and the like. This is a particularly common strategy among international students for whom the cost of travel to interview in person would be prohibitive. Do not make a pest of yourself, of course.

Programs that substitute telephone or video-conference interviews for in-person interviews are the exception rather than the rule. However, as already mentioned, some programs conduct an initial screening interview on the phone to gauge the applicant’s interest in and appropriateness for the program before inviting the candidate for an onsite interview. Normally, a program will send an email to schedule a time for this call so that the applicant can plan for it but, in some cases, the call can come without warning. With this in mind, you might want to try a strategy used by one successful applicant we know. He created an information sheet about each of the programs to which he had applied (e.g., faculty names, particular emphases and strengths) along with notes about his career interests and goals, and carried the notes with him at all times in case his next cell phone call was from someone on an admissions committee. He felt that if he received a call from a school to which he had applied, having this information handy would reduce his anxiety about the conversation and help him organize his responses so that his emphasis would be appropriate for each institution. This plan also ensured that he would include all the points he wanted to make during a call and thus avoid regret over failing to mention something important. He did receive a call and his strategy worked.

The same strategy can be used when you are contacted by email. Increasingly, graduate admissions committees deal with applicants solely electronically, so be sure to check your email (and your spam folder!) frequently throughout the application process. If you have a non–university-based email address with a provocative name (e.g., sexything555), then you should definitely set up an email account with a more professional address well before the application process begins. Also, double-check any quotations

or images that are sent automatically as part of your email signature because these sayings or images might not present you in the best light professionally.

Although social norms differ somewhat in the use of email, your email messages during the application process should be formal. Make sure to use proper grammar, punctuation, and spelling when communicating with a graduate program. Even contact with a graduate student or staff member should be professional, and keep in mind that these individuals often provide feedback to the admissions committee. Indeed, every contact you have with the university is another opportunity for the admissions committee to make judgments about your professionalism. To our knowledge, texting is rarely used for communication between applicants and programs, but if you do receive a text about your application—your response should be as formal and professional as possible.

While we are on the topic of technology, you should be aware that a number of admissions committees look for additional information about applicants by conducting searches on Facebook, Instagram, Twitter, LinkedIn, and other social media. They may also read material on your personal website or blog. You should do similar searches yourself, review what you find, consider what an admissions committee would think about you after reviewing your online presence, and consider editing your information (Behnke, 2007). This step is important not only to enhance your chances for admission, but also to burnish your professional image even after a graduate program has accepted you. The impression that others have of you online may have professional repercussions. Consider the fact that, for example, once you begin to work with clients, those clients might well search for information about you online. What impression would their search convey about their therapist? These points relate to many professional issues that

were discussed in Chapter 15, but they also are relevant during the application and interview process.

If you did not take part in a face-to-face interview, but were lucky enough to be admitted into more than one program, it is appropriate to visit each school and talk with department representatives and graduate students. Make an appointment well ahead of time by emailing the admissions coordinator or the Director of Clinical Training and ask to meet with clinical psychology faculty and graduate students. Be prepared to outline briefly the nature of your questions, and have a number of alternative visit dates in mind.

Often, students want to schedule interview appointments before they apply to a school or before they are admitted. Some departments, especially Psy.D. and master's programs, welcome early interviews. However, other departments have so many applicants that it is impossible to accommodate such requests. Usually, the information you gather through the methods mentioned earlier will be sufficient to help you decide whether or not to apply to a particular program. If the material you accessed is not sufficiently informative to give you a clear picture of a particular program, contact the department for additional details. Before doing so, though, be sure to carefully read the material you have on hand so that you do not ask about things that a department has already covered in its printed or online material. Once you are admitted, however, campus visits and interviews can help you to compare programs and guide your decision about which offer to accept.

How Do I Prepare for an Onsite Interview?

If you are invited for an interview, it means that you are in the final, relatively small (e.g., 10 to 35) pool of applicants to a particular program and thus have a reasonably good chance of eventually receiving an offer from that program. Exact percentages vary, but often a little over half of interviewees are ultimately admitted. To optimize the impact of your interview, both in terms of the information you gather and the impression you make, do some preparation and practice. Here are some specific suggestions.

1. Gather and read as much information about the program as you can. Become familiar with everything the program has sent you, as well as any additional information you can find on the internet. Nearly all graduate programs use their websites for recruitment purposes, so make sure to read everything on the clinical area website (including affiliated websites or attached documents, if they are provided). It is quite common for programs to show sample course sequences on their website, so make sure to familiarize yourself with these details before you show up for the interview.

2. Read and become familiar with several published articles by each of the faculty members with whom you are most interested in working. As you read these articles, make notes on topics that interest you and questions that the research raises.

3. Prepare yourself to talk at length about your own research experience. You should be able to describe the purposes of the research, the methodology, the primary results, and the lessons you have learned from this experience. It is a good strategy to prepare in advance a brief description of your research

experience and to practice presenting this brief summary. Do not assume you can just show up at the interview and spontaneously describe your research in a coherent and knowledgeable fashion. Be ready to answer questions such as:

- If you were to repeat the study, what might you do differently?
- If you could do a follow-up study, what might you want to look at?
- What research questions/areas intrigue you most right now?
- What surprised you about conducting this study or the results?
- What do you see as your strengths and weaknesses as a researcher?
- What do you enjoy most about the research process?
- What would make a graduate program a top fit for you?
- Why are you interested in obtaining a degree in clinical psychology?
- What type of career do you expect you'll want after graduation? E.g., mostly research, clinical work, or teaching…?

4. Plan the questions you will want to ask the faculty and graduate students. They will assume that you have questions and, if you are not prepared, the interview will end early and on a negative note. Try not to ask questions that can be answered by reading the information on the program's website (e.g., what courses will I take in my first year?). In addition, many of the "nuts-and-bolts" issues (e.g., financial support) are handled in group information sessions. Instead, in your faculty interviews, you should ask substantive questions that will better inform you about what it would be like to be a graduate student in this program. Appropriate topics include the faculty member's current and future research plans and mentoring style, the strengths

and weaknesses of the program, graduate student–faculty relations, opportunities for collaboration and training in particular areas (e.g., interdisciplinary work, advanced quantitative skills, grant writing), and the types of internships and jobs obtained by graduates from the program. Most faculty members at research-focused programs love to talk about research ideas—this is usually a big part of why they went into the field—so asking questions about current projects and upcoming grant plans can often be a good way to start exploring areas of potential collaboration.

Some programs offer to have their graduate students provide housing for you during your visit. Take them up on this offer because this is an excellent opportunity for you to spend time asking current graduate students about life in the program. You may want to ask them many of the same questions that you ask the faculty, especially those dealing with mentoring, student–faculty relations, and strengths and weaknesses of the program. It's also a good way to get more of an "inside scoop" about whether graduate students feel well supported in the program. A word of caution, however—it is very likely that the graduate students will offer feedback to the faculty regarding the applicants they have met. Therefore, do not say things that contradict what you told the faculty members and do not insult other applicants, students, or faculty. Further, if the students should happen to take you out socially after the interview, be careful about how you behave. The formal interviews may be over, but you will continue to be under scrutiny. So align your behavior —including the amount of alcohol you consume—to match your goal of being admitted. There are many cases in which applicants' chances for admission were ruined by things said or done late at night while out with the department's graduate students.

During the interview, you will want to come across as poised, mature, motivated, thoughtful, and interpersonally skilled. Remember that clinical program faculty will not only evaluate you in terms of your potential as a graduate student but also as someone whom they will feel comfortable sending into clinical settings. A good way to increase your poise and confidence during interviews is to practice role-played interviews before going on the visit. These mock interviews can be with a roommate or, better yet, with a graduate student or faculty member at your home institution. Make the interviews as realistic as possible. Dress appropriately, shake the person's hand, introduce yourself, and in all ways interact as if the interview were the real thing. Address the interviewing faculty members as "Dr." until and unless you are told to do otherwise.

What Kind of Financial Aid Is Available for Graduate Study?

As mentioned earlier, most Ph.D. programs in clinical psychology offer some form of financial aid to their students, while Psy.D. and master's-level programs are much less likely to do so. Financial aid comes in several forms: loans, fellowships, tuition remission, and work programs. The major source of financial aid for graduate students is the university in which they are enrolled, though aid may also be available through guaranteed loan programs (many of which are government sponsored) and national awards, which are competitive and have specific criteria for application. These awards are given directly to students for use at the school of their choice.

The availability of awards and loans changes regularly, so you should check with the financial aid officer at your college or at the institutions to which you are applying for current information. Because your financial support is most likely to come through the program to which you are admitted, the information you will receive with your application material is very important—read it carefully!

Fellowships and *scholarships* are given on many campuses as outright grants to support and encourage students with outstanding academic and research potential. These are few in number, and competition for them is fierce. Many fellowships and scholarships are used to encourage applications from especially talented people who have limited financial resources and/or are members of racial/ethnic minorities, or other groups that are traditionally underrepresented in Ph.D. psychology programs. Others are designed for applicants who have outstanding academic records or who have distinguished

themselves in other ways, such as by conducting or publishing research in a particular topic area.

Assistantships come in two forms: research assistantships and teaching assistantships. As their names imply, both entail working at jobs that require the graduate student to assist faculty in research projects or in teaching responsibilities (e.g., as a discussion leader, laboratory instructor, or grader). Assistantships usually require 10 to 20 hours of work each week. Although these positions have a work requirement, many graduate programs consider the work requirement to be part of students' training (e.g., learning to conduct research or to teach, respectively), so these positions are often helpful to students for what they *learn* in addition to what they *earn*.

Loan programs exist on most campuses as a way of assisting students to invest in their own futures. These loans usually carry a low interest rate, and repayment begins only after the student leaves graduate school. Students in Psy.D. programs are more likely than those in Ph.D. programs to need loans (Sayette & Norcross, 2018). This is because Psy.D. programs tend to be more expensive and are less likely to offer financial aid or paid teaching or research assistantship positions. Note that, partially due to the increasing default rate on federal student loans, the rules for these loans are becoming more restrictive. Time and credit limits for completion of master's and graduate programs may apply, and there are more restrictions on who is eligible, so think carefully about enrolling in a program whose cost may leave you with unmanageable debt.

Finally, as already mentioned, many programs offer some form of tuition remission. They may offer complete remission, meaning that the student pays no tuition at all, or they offer some portion of remission (e.g., 50%). Alternatively, the program may waive the out-of-state tuition and only

require that the student pay in-state tuition, even if the student is coming from out of state.

Not all types of aid are offered at all schools. Again, carefully read the financial aid information you receive to be sure you understand what is available at each school you are considering. Further, tuition costs differ dramatically across schools. If the program does not guarantee tuition remission to its students, then you must factor tuition costs into the equation when deciding where to apply. In addition to consulting the financial aid office website at the universities you are considering, you should explore other resources for information about applying for financial aid. These include, for example, Peterson's (2018) *Scholarships, Grants, and Prizes*. Note too that, as mentioned earlier, APA-accredited programs are required to provide information on the percentage of incoming students who received funding, so be sure to look for that information on the programs' websites when you are comparing programs. It will be in the section labeled "Student Admissions, Outcomes, and Other Data."

If you are accepted into a clinical psychology program that offers little or no financial aid, it is well worth your time to check on the availability of assistantships in departments outside psychology. For example, administrators of campus residence halls may hire graduate students to serve as hall counselors. Further, departments offering large undergraduate courses may not have enough graduate students in their programs to fill the teaching assistantships available and thus may "import" assistants from related areas. Identify your skills and experiences and seek out jobs that fit them. Note, however, that many programs require that you receive permission before working outside of the program, so double-check with your mentor or with the Director of Clinical Training before seeking employment on your own.

When I Am Admitted to a Program, How Long Will I Have to Make a Decision About Whether to Accept?

Most admissions offers include a specific deadline by which the student must accept or reject the offer. For doctoral programs, offers of acceptance and financial aid typically must be given to applicants by April 1, and applicants must respond by April 15. Realistically, offers from competitive programs often are given well before April 1, and many offers are made as early as February these days. The April 15 deadline for responding to an offer was adopted by the APA Council of Graduate Departments of Psychology to protect students from being pressured to make decisions before having full information about their alternatives (American Psychological Association, 2013e). Once you make a final decision about which offer to accept, you should convey that information to all programs at which you are still being actively considered. Your acceptance decision is considered binding after the April 15 date, although professional courtesy suggests that the decision is binding even if it is made before April 15. For further details on expectations regarding receiving and responding to graduate school offers in a timely way, see the CUDCP Guidelines for Graduate School Offers and Acceptances at https://cudcp.wildapricot.org/Resources/Documents/CUDCP%20Policy%20on%20Graduate%20Program%20Offers%20and%20Acceptances%20(FULL%20version).pdf.

Ideally, you will have ranked all your potential programs once you have completed your interviews so that you can provide quick feedback to programs once you begin receiving offers. For example, if you are lucky enough to get an early offer from your top choice, you should quickly accept

the offer and then withdraw your applications from the other programs. Similarly, if you receive an offer from your third choice, you should withdraw your applications from your fourth and lower choices but hold onto the acceptance at your third choice while waiting to hear from your first and second choices. Overall, if you have decided not to accept an offer, courtesy dictates informing the department of that decision as soon as possible. This courtesy will be appreciated by the department and may provide space for another student. If you do not receive an acceptance by April 1, you may be the one who appreciates an applicant turning down an offer quickly, since it may free up a space for you.

Will I Be Successful in Gaining Admission?

Obviously, we can't answer this question with certainty, but we hope the information and suggestions presented here will be helpful. A careful examination of your own credentials and the advice of those who have experience with students applying to graduate school in clinical psychology will help you apply to appropriate programs and maximize your chances of admission.

It may also be helpful to hear about the winding path to graduate school that has been taken by successful applicants. One recent survey (Werntz et al., 2019) of more than 700 current clinical doctoral students at CUDCP Ph.D. programs indicated that 73% of them applied only to clinical Ph.D. programs, while the others applied to clinical Ph.D. programs along with other types of programs (e.g., Psy.D. or Master's programs). In the year they were admitted, students reported applying to an average of 10 clinical Ph.D. programs each, but the range was enormous (from 1 to 27!). Also, one-third of these students reported having applied to graduate school more than once, reinforcing the idea that it is common to need to re-apply during a later application cycle after further strengthening one's application.

We also encourage you to review "Kisses of Death in the Graduate School Application Process" (Appleby & Appleby, 2006). This article reports results of a survey of heads of graduate school admissions committees in psychology that asked about applicant actions that decreased their chances of admission. The results summarize many of the things we have warned you about in this chapter, such as submitting personal statements that are too revealing, asking questions that suggest you have not bothered to read

available information, having typos or grammatical errors in written materials, and the like. So if you read this chapter carefully, most of these mistakes are easy to avoid.

We wish you success in your application process!

What Are Your Rights as a Graduate Student?

While there is no doubt that being a graduate student carries many demands and responsibilities, it is also important for you to understand what you have the right to expect. Different programs will promise different support packages and each mentor-student relationship is unique, but the American Psychological Association of Graduate Students (APAGS) has developed some general guidelines that they consider “indispensable to the fair, equitable and respectful treatment of every psychology graduate student throughout their education and training” (https://www.apa.org/apags/issues/student-rights-position).

The APAGS Position Statement on the Rights of Psychology Graduate Students details rights tied to five areas: (a) institutional environment (e.g., the right to receive respectful treatment by the faculty, colleagues, staff, and peers); (b) program policies (e.g., the right to publicly available and accurate information about the program and expectations); (c) professional and educational training opportunities (e.g., the right to quality training in teaching, research, clinical practice, and quality mentorship); (d) work environment (e.g., the right to fair compensation for services provided and the chance to work in an environment free of harassment or intimidation); and (e) appeals and grievances (e.g., the right to due process). In short, you should expect to work very hard during graduate school, but to also be treated with respect!

Chapter Summary

This chapter provided information on various career options for the helping professions and reviewed the requirements and procedures for applying to graduate training programs in clinical psychology. There are a number of paths that can lead to a career as a therapist, including earning a master's degree, Ph.D., or Psy.D. degree in clinical psychology, a master's or Ph.D. degree in counseling psychology, a Ph.D. degree in school psychology, a specialist degree in education (E.D.S., Ed.D.), or, a master's or doctorate in social work, a master's degree in rehabilitation counseling, a medical degree in psychiatry or behavioral pediatrics, or a nursing degree in psychiatric nursing.

Depending on which career they are interested in pursuing, students can use coursework, research experience, clinical experience, and extracurricular activities to prepare for their career. Salaries vary across careers, with doctoral-level jobs typically paying more than master's-level positions.

There are a number of different training options in clinical psychology for students to consider, including a master's, Ph.D., or Psy.D. degree. If they are seeking a doctoral program, it is important to consider whether the program is accredited by APA or PCSAS, or unaccredited, and the relevant implications for licensure eligibility in different states.

Students who are educated about the process of applying to graduate programs should fare better than those who are not. There are significant personal and financial commitments required of graduate students, so you must evaluate your own motivation and goals before proceeding. If your

motivation and energy are strong, then the components of the application process and the process itself should be manageable. The primary components of the application are finding a good fit based on research interests, GRE scores, GPA, letters of recommendation, and personal statements. The process of applying is complex so it is important to do your homework and not leave it to the last minute. In general, persistence and conscientiousness are encouraged throughout this process. Good luck!

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Answer Key

Chapter 1

An Overview of Clinical Psychology

1. doctoral; master’s

2. do not

3. also

Clinical Psychologists at Work

1. direct service (or therapy); private practice

2. Research

3. cultural sensitivity

Clinical Psychology in the 21st Century

1. internal; external

2. What am I being asked to believe?

3. Clinical research; clinical experience; client characteristics and preferences

Chapter 2

The Roots of Clinical Psychology

1. children

2. astronomy

3. Philippe Pinel

Clinical Psychology Begins to Grow

1. 1945

2. Testing

3. 1945

Clinical Psychology Branches Out

1. active

2. phenomenology

3. behavioral

Chapter 3

An Outline of the Assessment Process

1. referral question

2. characteristics of the client and the goals of assessment.

3. psychometric properties.

The Goals of Clinical Assessment

1. matching disorders to treatment, helping researchers identify clients' disorders, ease communication among mental health professionals.

2. dimensional

3. rare

Factors Influencing the Choice of Assessment Instruments

1. test–retest reliability

2. construct validity

3. low; high

Clinical Judgment and Decision-Making

1. their own experience; evidence from clinical research

2. clinical data; statistical formulas; final decisions

3. confirmation bias

Communicating Assessment Results

1. clearly written

2. assessment outline; theoretical orientation

3. incremental validity

Chapter 4

Clinical Interview Situations

1. conversation with a purpose or goal.

2. debriefing

3. underutilization of mental health services.

Interview Structure

1. crisis

2. structured

3. unstructured

Stages in the Interview

1. make the client feel comfortable

2. directive

3. nonverbal; reflection

Research on the Interview

1. confirmation bias

2. the same

3. reduce

Observational Assessment

1. confirmation bias

2. signs; samples

3. calibration

Approaches to Observational Assessment

1. self-monitoring

2. controlled

3. naturalistic; controlled

Research on Observational Assessment

1. lower

2. decrease

3. high; low

Chapter 5

Basic Concepts in Psychological Testing

1. standardized

2. empirical

3. malingering

Tests of Intellectual Functioning

1. think or reason; solve problems; learn

2. false

3. common factors; specific

Tests of Psychopathology and Personality

1. empirical

2. low (or limited)

3. projective

The Current Status of Psychological Testing

1. the MMPI

2. intelligence, objective personality, projective personality

3. clinical utility

Chapter 6

Overview of Clinical Interventions/Major Approaches to Psychotherapy

1. professional relationship

2. less

3. approach

The Participants in Psychotherapy

1. therapeutic alliance

2. genuineness, empathy, and unconditional positive regard

3. have their own therapy

The Goals of Clinical Interventions/ Goals of Psychotherapy

1. unconscious; self-knowledge

2. a level the client can understand

3. placebo effect

Ethical Guidelines for Clinical Interventions

1. Conflict of interest

2. supervisors; colleagues

3. values

Some Practical Aspects of Clinical Intervention

1. psychoanalytic (or psychodynamic)

2. top-down (or therapist based)

3. humanistic

Chapter 7

Methods for Studying Psychological Treatments

1. independent variables; dependent variables.

2. internal

3. randomized controlled trials

Results of Research on Individual Treatments

1. representative; scientific

2. design quality

3. sensitive

Results of Research on Other Modes of Intervention

1. unnecessary

2. behavioral and structural family therapies

3. psychotherapy

Issues and Concerns about Research on Psychotherapy

1. external

2. efficacious; effective

3. dissemination

Chapter 8

Psychoanalysis

1. free association

2. transference

3. defense mechanisms

Psychodynamic Psychotherapy

1. psychodyamically oriented

2. false

3. object relations

Interpersonal Psychotherapy

1. relationship distress

2. death of a loved one; conflict with family members, friends, or coworkers; a significant role transition; or insufficient meaningful interpersonal relationships

3. non-specialist providers

Humanistic Psychotherapy

1. therapeutic (or therapy or client–therapist) relationship

2. false

3. existential

Chapter 9

Behavior Therapy

1. reinforcement, pleasure, mastery

2. hierarchy, avoidance

3. assertiveness training; social skills training

Cognitive Therapy

1. Socratic; guided discovery

2. labeling

3. schemas

Cognitive Behavior and Acceptance-Based Therapies

1. empirical

2. second

3. mindfulness or acceptance

Chapter 10

Dissemination and Implementation of Clinical Interventions

1. what; how

2. informal interventions, formal but not mental health-specific interventions, complementary and alternative interventions, and population based interventions

3. non-specialist providers; settings

Group Therapy

1. 6 to 12; confidential

2. homogenous; heterogeneous

3. psychoeducational

Couples and Family Therapy

1. distress; communication difficulties

2. social relationship system

3. behavioral

Alternatives to In-Person Therapy by Mental Health Professionals

1. reduced

2. eHealth (or mHealth or digital therapeutics)

3. primary prevention (or universal mental health prevention)

Chapter 11

A Brief History of Clinical Child Psychology

1. DSM-II

2. developmental psychopathology

3. bullying (or suicide or increased use of drugs to treat childhood disorders)

Unique Characteristics of Clinical Child Psychology

1. norms

2. children; more; adults

3. children; adults

Clinical Assessment of Children

1. behavior rating scales

2. norms

3. interviews

Treatment and Prevention of Child and Adolescent Disorders

1. anxiety; ADHD

2. older; anxiety; depression

3. deviancy training

Clinical Geropsychology

1. 100

2. ageism or age bias

3. successful aging or healthy aging

Unique Characteristics of Clinical Geropsychology

1. Pikes Peak Model

2. birth cohort

3. bio-psycho-socio-spiritual

Clinical Assessment with Older Adults

1. physical; psychological or emotional

2. medical records

3. activities of daily living

Treatment of Older Adults

1. lower; suicide

2. psychological; pharmacological

3. internalized ageism

Chapter 12

What Is Health Psychology?

1. stressor; stress reaction

2. biopsychosocial

3. emotion focused (specifically suppression)

Risk Factors for Illness

1. half

2. social

3. against

Illness Prevention and Treatment Programs

1. opioid

2. cope with

3. fatigue, pain, depression

Improving Adherence to Medical Treatment

1. treatment compliance

2. health belief

3. continency contracts

Chapter 13

A Brief History of Neuropsychology

1. localization of function

2. equipotentiality

3. corpus callosum

Basic Principles of Neuropsychology

1. modules

2. language

3. right

Patterns of Neuropsychological Dysfunction

1. prosopagnosia

2. executive function

3. dementia

Neuropsychological Assessment

1. less

2. battery (or standardized); individual

3. norms

Neuropsychological Approaches to Psychopathology

1. depression

2. prefrontal; left

3. nonverbal

Chapter 14

The Scope of Forensic Psychology

1. interviews; tests

2. law enforcement

3. prison

Criminal Competence and Responsibility

1. mental hospital; treatment to restore competence

2. *mens rea* (guilty mind)

3. whether the defendant is sane or insane

Assessing Psychological Status in Civil Cases

1. tort actions

2. combat stress or posttraumatic stress disorder

3. physician-assisted suicide

Psychological Autopsies and Criminal Profiling

1. a defendant's sanity at the time a crime was committed

2. no

3. FBI

Child Custody and Parental Fitness

1. joint; sole

2. MMPI-2

3. the children

Mental Health Experts in the Legal System

1. civil; criminal

2. the presiding judge

3. memory

Chapter 15

Professional Training

1. clinical science

2. practitioner–scholar

3. scientist–practitioner

Professional Regulation

1. content knowledge; professional skill

2. reciprocity

3. continuing education

Professional Ethics

1. ethical standards

2. predicting genuine dangerousness

3. confidentiality

Professional Independence

1. insurance panels

2. more

3. medical and physical sciences

Professional Multicultural Competence

1. women; people of color (or minorities)

2. often, but not always

3. are not

The Future of Clinical Psychology

1. positive psychology

2. climate change

3. dissemination

Name Index

Aarons, G. A., 245
Abba, K., 414
Abbass, A., 228
Abbott, R. D., 406
Abdullah, T., 345
Abeles, N., 503
Aber, J. L., 344, 370, 511
Abernethy, A. P., 409
Aberson, B., 344
Abood, L. G., 37
Abramowitz, J. S., 290, 293, 333
Abrams, D., 407
Abramson, L. Y., 305
Abreu, I., 244
Abreu, J. M., 109
Abt, L. E., 42
Achenbach, T. M., 133, 354, 357, 359, 372
Achenbaum, W., 377
Achter, J. A., 236
Acierno, R., 338
Ackerman, N. W., 132
Ackerman, P. L., 152

Acree, M., 512
Adams, G., 506
Adams, M. R., 404
Addis, M. E., 244
Adelman, H. S., 373
Adi, A., 494
Adler, A., 106, 264–265, 268, 344
Adler, N. E., 405
Ægisdóttir, S., 91, 93
Afari, N., 389
Agnew, C. R., 133
Agnew-Davies, R., 196
Agorastos, A., 398
Agras, W., 320
Aguilera, A., 339
Ahlstrom, B., 413
Ahn, H., 244
Ai, A. L., 512
Ainsworth, M. D. S., 266
Ajoku, C., 471
Aklin, W. M., 108
Al-Bedah, A. M., 347
Albee, G. W., 28, 345
Alberts, F. L., 352
Albright, T. D., 449
Alcantara, C., 18
Al-Dajani, N., 171
Aldwin, C. M., 376

Alegría, M., 105, 127, 198, 373
Alessi, S. M., 331
Alexander, F., 267, 269
Alexander, L. B., 196
Alexander, R. W., 462
Alfonso, C. A., 267–268
Allen, B., 245
Allen, D. N., 439
Allen, G. J., 133
Allen, J. M., 97
Allen, R. S., 379
Alleyne, E., 411
Allport, G. W., 165
Almeida, A., 88
Almqvist, F., 372
Alonso, J., 28, 329
Alonso-Fernandez, M., 389
Alper, B. S., 245
Alter, K., 428
Alterman, A. I., 113
Altman, D. G., 224
Altweck, L., 3
Alvarado, R., 240
Ambrosino, 9
Amertrano, R. M., 204
Ametaj, A. A., 245
Amlung, M., 306
Amsbaugh, H. M., 463

Amundson, M. E., 399
Anand, A., 343
Anastasi, A., 165, 173
Andersen, B. L., 410
Andersen, K., 209
Anderson, J. L., 171
Anderson, N. B., 404
Anderson, T., 501
Andersson, G., 209, 241, 338
Andersson, G. W., 58, 140
Andreasen, N. C., 115
Andrews, B. V., 332
Anestis, J. C., 262
Anestis, M. D., 262, 268
Anglin, R. E., 382
Angold, A., 109
Anthony, J. C., 382
Antoni, M. H., 404, 412
Antonsen, P., 212
Antony, M. M., 139, 171, 197, 286, 289–290, 292–293, 328, 330
Apodaca, T. R., 347
Appelbaum, P. S., 463
Appleby, D. C., 549
Appleby, K. M., 549
Arasteh, J. D., 469
Archer, R. P., 169
Archer, T., 415
Ardito, R. B., 196

Arean, P. A., 380
Arias, E., 375
Arkowitz, H., 240
Arnkoff, D. B., 58, 204, 510
Arnold, C. B., 409
Arnold, D. H., 113
Arnold, M., 389
Aronson, E., 93
Aronson, J., 163
Arrigo, B. A., 449, 469
Asarnow, J. R., 320
Asbridge, M., 409
Asmundson, G. J., 58
Asnaani, A., 321
Asscher, J. J., 240
Atanackovic, D., 398
Atkins, D. C., 60
Atri, A., 437
Aune, D., 405
Austin, E. J., 159
Austin, J., 364
Ayalon, L., 380
Ayearest, L., 150
Ayearst, L. E., 82
Ayers, C. R., 388
Ayers, S., 511
Azagba, S., 409
Azar, B., 410

Azar, S. T., 382

Ba, P., 506
Baardseth, T. P., 232, 321
Babinski, M. J., 428
Babor, T. F., 114
Babyak, M., 415
Baca-Garcia, E., 81
Bachelor, A., 199
Bachman, C. M., 512
Bagalman, E., 19
Bagby, R. M., 82, 125–126, 171
Bagchi, D., 113
Bähner, F., 443
Bailey, D. S., 471
Baird, A., 428
Baker, D. B., 31, 33–35, 41, 43–44, 58, 144
Baker, M., 233
Baker, T. B., 22–23, 481
Baldwin, S., 236–237, 238, 239, 328–329
Bandura, A., 204, 302
Bangert, L., 339, 374
Bantha, R., 512
Bar-Anon, Y., 261
Barbaree, H. E., 136
Barber, J. P., 5, 197, 487
Barbin, J., 410
Barden, R. C., 456
Bardos, A. N., 161

Barker, C., 58
Barker, R., 469
Barker, W. W., 436
Barkham, M., 209
Barkley, R. A., 367
Barlow, D. H., 59, 139, 171, 221, 242, 244–245, 296, 306, 321, 383, 513
Barnett, H., 195
Barnett, J. E., 492, 499
Barnett, N. P., 225
Barr, S. J., 409
Barrera, M., 372, 503
Barrett, P., 172
Barrett, P. M., 369
Barry, C. T., 357, 361
Bartholomew, T. T., 110
Bartol, A. M., 466
Bartol, C., 466
Barton, J. J., 433
Baskin, D., 109
Bateson, C., 335
Baucom, D. H., 239, 333–334
Baude, A., 469
Baum, A., 396, 410
Baumeister, R. F., 401–402
Bayer, U., 428
Beach, S. R. H., 72, 332
Bear, D. M., 433
Beardslee, W. R., 344, 370, 511

Bearse, J. L., 194
Beauchaine, T. P., 354, 373
Beavers, G. A., 129
Bechtoldt, H., 283
Beck, A. T., 50–51, 77, 114, 171, 181, 302, 307–308, 330
Beck, J. C., 495
Beck, J. G., 383
Beck, J. S., 86, 203, 308–310, 321
Beck, S., 174
Beckner, V. L., 210
Becvar, D. S., 336
Bee, H., 333
Beekman, A., 505
Beekman, A. T., 241
Begley, S., 186
Behnke, S., 492, 544
Behrmann, M., 433
Beidel, D. C., 102, 171
Beier, M. E., 152
Belar, C. D., 479, 484
Bell, C. C., 108
Bell, E., 533
Bellack, A. S., 135, 298
Bellak, L., 360
Belsher, B. E., 81
Benbow, C. P., 153
Bender, S. D., 126
Benjamin, L. T., 30–31, 33–35, 41, 43–44, 58, 114, 144, 482

Benjet, C. L., 471
Bennell, C., 467
Bennett, B. E., 492–493, 495
Bennett, C. B., 211
Ben-Porath, Y. S., 148, 169
Benson, L. A., 239, 510
Benuto, L., 506
Berg, H., 212
Berg, I. A., 150
Bergin, A. E., 227–228
Berglund, P., 188
Bergman, A., 265
Bergström, B., 419
Berkowitz, D., 458
Berle, D., 320
Bernal, G., 505–506
Bernstein, D. A., 53, 68, 81, 135, 138–139, 163, 170, 172, 202, 291–292, 365, 368, 410, 450–451, 456, 458, 474
Bernstein, J. H., 444
Berry, S. L., 483–485
Bertelsen, A. 75
Berti, A., 429
Bessel, F. W., 34, 39
Beswick, A., 409
Betan, E. J., 268
Betts, K., 522
Betz, N. E., 156
Beutel, M. E., 105

Beutler, L. E., 25, 65, 70, 76, 113, 139, 144, 189–191, 198, 211, 232
Beyerstein, B. J., 458
Bhattacharjee, S., 443
Biaggio, M., 503
Bianchi, K., 456, 458
Bickman, L., 480
Bieling, P. J., 328, 330
Bierhaus, A., 407
Bigelow, C., 126
Biglan, A., 240, 344, 511
Bigler, E. D., 440
Bike, D. H., 194–195
Bilese, P. D., 106
Billingsley, J. T., 528
Binder, J. L., 268
Binder, P.-E., 212
Binet, A., 35, 38–39, 154–156, 422
Birks, Y., 406
Birren, J., 377
Bisiach, E., 429, 432
Bisson, J. I., 296
Biswas-Diener, R., 511
Björck, L., 399
Black, D. S., 347
Black, D. W., 73
Black, L., 244
Blackburn, H., 409
Blackwell, S. E., 224

Blakely, C., 133
Blakey, S. M., 293
Blanchard, E. B., 410
Blanchard, R., 136
Blanco, C., 28
Blank, K., 27
Blankenship, D. M., 108
Blase, S. L., 27, 61, 219, 237, 324, 459
Blatt, S. J., 266
Blazer, D., 377
Blazer, D. G., 382
Bledsoe, S. E., 522
Bleiberg, K., 269
Bleich-Cohen, M., 443
Block, C., 409
Bloom, L. J., 468
Bluestone, H., 109
Blumenthal, J. A., 408
Bobbitt, B. L., 26
Bochsler, K., 190
Bodner, G. E., 297
Boelcke-Stennes, K., 512
Bogels, S. M., 103
Bogousslavsky, J., 431
Bohart, A. C., 195, 272
Boisvert, C. M., 245
Bojesen, A. B., 209
Bolger, N., 402

Bolton, P., 271
Bond, L., 179
Bond, R., 317
Bondi, R. J., 437
Bondy, E., 126
Bonnici, D., 495
Bonnie, R., 453, 463, 474
Bonnie, R. J., 457
Borden, V. M. H., 7
Borden, W., 7, 258, 261
Borelli, G., 422
Borghans, L., 179
Boring, E. G., 32, 152
Borkovec, T. D., 139
Borneman, M. J., 162, 164, 179
Bornstein, R. F., 74
Borsari, B., 225
Borson, S., 385
Bosch-Capblanch, X., 414
Boska, P., 13
Bosley, H. G., 234, 315
Bosmajian, C. P., 514
Boss, A. R., 132
Boswell, J. F., 204
Botello, T., 465
Bottoms, B. L., 542
Bouchard, S., 136
Boucher, A. P., 488

Bougakov, D., 435
Boulger, J. R., 79
Bower, E. S., 389
Bower, J. E., 401
Bowlby, J., 266, 270
Boyd, D., 333
Boyd-Franklin, N., 88
Boyle, M. O., 152
Boysen, G. A., 109
Brabender, V., 74
Bracha, H. S., 72
Braden, J. P., 159
Bradley, R., 223
Bradshaw, P. W., 413
Braginsky, B. M., 126
Braginsky, D. D., 126
Brambilla, P., 443
Brand, R. J., 406
Brannon, L., 402
Bransford, J. D., 92
Branthwaite, A., 413
Brauer, B. A., 168
Braver, S. L., 468
Bray, J. H., 511
Breggin, G. R., 367
Breggin, P. R., 367
Breier, J. I., 429
Brekke, N. J., 474

Brems, C., 190, 192, 208
Brenes, G. A., 382
Breuer, J., xxi, 252–253
Breuner, C. C., 347
Brewer, N., 450
Breyer, S., 474
Bridges, S. K., 266
Briesmeister, J. M., 239, 335
Briggs, K. C., 173
Briggs, M., 125
Bright, M. M., 503
Brill, A. A., 38
Broca, Paul, 250, 421–422
Brodersen, K. H., 433
Brody, E. M., 383
Brody, G. H., 369
Bromet, E. J., 108
Brondolo, E., 407
Brotemarkle, R. A., 32
Brotman, L. M., 370
Brotman, M. A., 236
Brown, C. L., 234, 315
Brown, D. J., 136
Brown, G. K., 171, 181
Brown, M. A., 347
Brown, M. T., 413
Brown, P. J., 197
Brown, R., 236

Brown, R. P., 348
Brown, R. T., 361
Brown, T. A., 383
Brown, T. L., 345
Browne, A., 330
Brownell, H. H., 428
Bruce, M. L., 240
Bruce, N., 236
Bruchmüller, K., 115
Brugha, T. S., 113
Bruijniks, S. J., 321
Brussel, James, 466
Bryan, A. D., 240
Bryan, C. J., 514
Bryant, W., 197
Buchanan, A., 81
Bucher, M. A., 236
Buck, B., 108
Buck, J. N., 177, 360
Buckley, P. J., 102, 104
Buckman, J. R., 58
Budge, S. L., 191
Bufka, L., 22
Bugental, J. F. T., 282
Bui, E. T., 409
Bull, S. S., 409
Bullis, J. R., 245
Bullock, H. E., 345

Bunde, J., 406
Bundy, C., 118
Bundy, T., 458
Bunte, T. L., 132
Burg, M. M., 407
Burger, W., 474
Burisch, M., 146
Burke, B. L., 52–53, 365
Burke, M., 409
Bürkner, P. C., 239
Burlingame, G. M., 238, 328–329
Burnes, D., 383
Burns, D. D., 191, 203, 346
Buros, O. K., 41, 144
Burt, K. B., 352
Busch, A. B., 188
Buser, J. K., 19
Bush, N. E., 514
Bush, T., 416
Bussell, J. K., 413
Butcher, J. N., 148, 169, 179
Butler, R., 377
Butters, N., 422, 439
Byers, A. L., 387
Byrne, S. P., 318

Cabaniss, D., 258
Cabeza, R., 433
Cacciola, J. S., 113

Cacioppo, J. T., 511
Cacioppo, S., 391
Caetano, R., 108
Cai, D. J., 433
Callaghan, G. M., 196
Callahan, J. L., 190
Caltagirone, C., 427
Calverley, K. L., 428
Camara, W. J., 144
Campbell, C., 5
Campbell, D., 5, 165
Campbell, D. T., 84
Campbell, E. M., 72
Campbell, L., 409, 492
Campbell, L. F., 7, 346
Campbell, T., 474
Canales, J., 34
Canino, G., 373
Canli, T., 52
Canning, D., 411
Canon, B. J., 186
Cantor, N. L., 153
Cantor, D. W., xxii
Cantor, J. M., 136
Cantor, N. L., 464
Caplan, G., 342
Caplan, P. J., 109
Cardemil, E. V., 234

Carei, T. R., 347
Carey, B., 60, 223
Carlbring, P., 338, 347
Carlomagno, S., 427
Carlson, C. A., 449
Carlson, J. F., 41, 144, 171
Carneiro, C., 135
Carpenter, B. D., 388
Carpenter, J. K., 328
Carpenter, L. A., 361
Carr, A., 514
Carr, W., 336
Carroll, F., 116
Carroll, J. B, 153
Carroll, K. M., 191, 199
Carstensen, L., 376
Carter, R., 343
Cartwright, D. S., 218
Carver, C. S., 399, 511
Casey, G. W., 514
Casey, L. M., 512
Cash, H. R., 383
Cashel, M. L., 359
Caspi, A., 10, 261
Cassel, E., 81, 368, 449–451, 456, 458, 474
Castellani, A. M., 239
Castle, P. H., 58, 522–523
Castonguay, L. G., 190, 203, 244, 506

Castro, C. A., 106
Castro, F. G., 372, 503
Catlin, C., 288
Cattell, J. McKeen, xxi, 35, 39
Cattell, R. B., 173
Cauffman, E., 81
Cautin, R. L., 235
Cavanagh, K., 317, 338
Cavanaugh, J. L. Jr., 114
Cederna-Meko, C. L., 373
Chabot, D. R., 332, 335
Challú, L., 213
Chambless, D. L., 22, 59, 204, 228, 231, 245
Chan, A. S., 459
Chan, A. T., 382
Chan, M., 398
Chang, T., 346
Chao, P. J., 198
Chapman, J. P., 92
Chapman, L. J., 92
Charcot, J.-M., 38–39, 252
Chavez, L. M., 373
Chechlacz, M., 432
Chekroud, A. M., 188
Chen, C.-M., 387
Chen, E. Y., 320
Chen, K.-H., 234, 315
Chen, P., 385

Chentsova-Dutton, Y., 18
Cherry, D. K., 483
Cheung, F., 109
Cheung, F. M., 169
Chibnall, J. T., 449
Chien, P. L., 108
Chiesa, A., 317
Childress-Beatty, L., 493
Chiu, H.-C., 387
Chmielewski, M., 125
Chochinov, H. M., 388
Choi, E., 18
Choquet, D., 441
Chorpita, B. F., 343, 366
Choukas-Bradley, S., 92, 374
Chow, L. Y., 110
Chowdhary, N., 505–506
Christensen, A., 218, 239, 332
Christensen, J. F., 396
Christenson, A., 510
Christian, C., 261
Christiansen, A., 60
Christidis, P., 3, 12, 16, 18
Christon, L. M., 317
Christopher, K., 36
Church, A. S., 150
Church, A. T., 169
Churchill, A. M., 281

Cianfrini, L. R., 409
Cicernone, K. D., 441
Cipriani, A., 367
Ciulla, R. P., 514
Clark, D., 116, 326
Clark, D. A., 308
Clark, D. B., 133
Clark, D. M., 28, 59, 326
Clark, L. A., 72, 75, 83, 125
Clark, S. E., 449
Clarkin, J. F., 211
Clarkson, T. B., 404
Claro, S., 163
Clavet, G., 474
Clay, R. A., 73, 488, 498, 514, 523
Clerkin, E. M., 308
Clingempeel, W. G., 468
Clough, B. A., 512
Cluxton-Keller, F., 240
Coalson, D. L., 158
Coatsworth, J. D., 352, 372
Cobb, H. C., 9, 164
Cobb, J. A., 132
Cobos, P. L., 108–109
Cochran, B., 242
Coffino, B., 512
Cohen, A. S., 109
Cohen, D., 201

Cohen, J. B., 406
Cohen, M. J., 334
Cohen, S., 398–399, 401–402
Coid, J., 81
Coid, J. W., 80
Colavito, V. A., 176
Cole, P. M., 373
Colello, K., 378
Coleman, P., 346
Coley, B., 411
Collings, A. S., 373
Collins, J., 32
Collins, R. L., 135
Collins, S., 452
Colmen, J. G., 79
Colodro-Conde, L., 52
Colom, R., 153
Colucci, V. A., 360–361
Comas-Diaz, L., 88
Comer, J. S., 219, 223, 243, 245, 335
Compas, B. E., 400
Comtois, K. A., 320
Conaway, K., 339, 374
Connelly, B. S., 162, 164, 179
Connelly, L. M., 133
Connery, A. L., 254
Consoli, A. J., 25
Constantino, M. J., 197, 204, 236

Conway, C. C., 74, 290
Cooke, D. J., 80
Coolidge, F. L., 103, 113, 115
Cooper, Z., 135
Cope, C., 3–5
Copeland, W. E., 368
Coral, N., 444
Corboz-Warney, A., 135
Corey, G., 328, 330
Cormier, S., 102, 190, 192
Cornell, A. S., 19
Correa, A. A., 181
Correll, C. U., 109
Corrigan, P. W., 345
Corti, M. D., 429
Corwin, D., 116
Coslett, H. B., 433
Costa, P. T., 150, 173, 179
Costello, F., 92, 128
Côtè, S., 136
Cottler, L., 116
Cotton, S., 512
Couch, R. D., 105
Coughlan, G., 440
Cowey, A., 431
Cox, D. R., 488
Coyne, A. E., 197–198, 204
Craig, R. J., 102, 117, 125

Craighead, W. E., 242
Crane, D. R., 209
Craske, M. G., 290–291, 321
Craven, R. G., 144
Crisp, H. L., 372
Cristea, I. A., 320, 340
Crits-Christoph, P., 190, 196–197, 328–329
Cronbach, L. J., 83, 85, 130
Cronshaw, S. F., 126
Crosbie-Burnett, M., 469
Crossley, M., 428
Crosson, B., 441
Crow, T. J., 443
Crowther, M. R., 379
Crum, A. J., 204
Csikszentmihalyi, M., 400
Cuijpers, P., 209, 236, 239, 241, 271, 338, 340, 374
Culbertson, S. S., 127
Cullen, R. M., 467
Cumming, J. D., 202
Cummings, E. M., 134
Cummings, N. A., 396
Cunningham, M. D., 81
Cunningham, W., 308
Currie, D., 395
Currier, J. M., 212
Curtin, L., 331
Curtis, J. T., 211

Cuthbert, B. N., 61

Dadds, M., 369
Dadds, M. R., 135
Dahlstrom, W. G., 168
Dahmer, J., 458
Daleiden, E. L., 366
Damasio, A. R., 434
Dana, J., 92, 127
Dana, R. H., 87
D'Angelo, H., 325
Daniel, J., 203
Daniel, J. H., 355
Daniel, M., 419
Danner, D. D., 401
d'Apice, K., 132
Darwin, C., 34–35
Dattilio, F. M., 196, 465
Davanloo, Habib, 267–269
Davey, C. G., 241
Davey-Smith, G., 409
David, R., 503
Davido, B. J., 503
Davidson, J. E., 152, 407
Davidson, K. W., 407
Davidson, P. R., 297
Davidson, W. S., 133
Davies, J., 473
Davis, D. E., 511

Davis, D. M., 134
Davis, J. D., 347
Davis, J. M., 195
Davis, K. M., 347
Davis, M. A., 336, 510
Davis, S. D, 193
Davis, W. W., 125
Davison, G. C., 59, 233
Davison, L. A., 422
Dawes, R., 92, 127
Dawes, R. M., 26, 93, 126
De los Reyes, A., 361
De Smet, M. M., 219
Deans, C., 25
Deary, I. J., 179
Debast, I., 376
DeBruyn, E., 92
Debus, R. L., 144
Deci, E. L., 190
Decker, S. E., 191, 199
Decker, S. L., 156
DeCou, C. R., 320
DeGeest, D., 84
Degenhardt, L., 514
Degnan, A., 505
DeGue, S., 484, 487
Dekel, R., 212
Dekker, J., 505

Deković, M., 240, 344
Del Re, A. C., 196–197, 236
Del Rey, R., 374
DeLeon, I. G., 288
DeLeon, P. H., 501
DeLillo, D., 484
Delisle, G., 279
DeLongis, A., 400
Demakis, G. J., 463
DeMaria, A., 244
DeMatteo, D., 474
DeMause, L., 253
DeMers, S. T., 488
Demkow, U., 13
Demler, O., 19, 188
Dennhardt, A. A., 225
Dennis, W., 35, 41
DeRight, J., 434
Derksen, J. J. L., 168
DeRobertis, E. M., 283
deRoon-Cassini, T. A., 365
DeRubeis, R. J., 236, 313, 321
Detrick, P., 449
Detterman, D. K., 153
Detweiler, J. B., 401
Detweiler-Bedell, J., 316
Deutsch, R. M., 471
Devlin, A. S., 199

Dew, I. T., 433
DeYoung, P. A., 266
Diamond, M. J., 261
Diaz, P., 468
Dickens, S. E., 126
DiClemente, C. C., 417
Diener, E., 400
Dierickx, K., 437
Diez Roux, A. V., 405
Digdon, N., 48
Diguer, L., 229
DiGuiseppe, R., 58, 321
DiLillo, D., 487
Dillon, H. R., 388
Dimaggio, G., 211
Dimatteo, M. R., 105
DiMatteo, R., 413
Dimoff, J. D., 7, 482
Dinger, U., 197, 202
Dinges, D. F., 125
Dipboye, R. L., 125
Dishion, T. J., 371
Dittmann, M., 6
Dix, D. L., 37
Dobson, K. S., 196, 223, 321, 400
Docherty, N. M., 109
Doctor, J., 190
Doherty, W. J., 336

Dohrenwend, B. S., 397
Doleys, D. M., 409
Doll, H., 80
Dollard, M. F., 462
Dombrowski, S. C., 153
Domenech Rodríguez, M., 505
Domenech Rodríguez, M., 506
Domino, G., 145, 153, 163, 174, 177, 179
Domino, M. L., 145, 153, 163, 174, 177, 179
Donders, J., 446
Donenberg, G. R., 227
Dong, L., 321
Donn, J. E., 43
Donoghue, J. R., 139
Doody, R. S., 437
Dorken, H., 396
Dornan, T., 118
Doss, A. J., 364
Doss, B. D., 332
Dougall, A. L., 396–397
Dougher, M. J., 72
Douglas, C., 258
Douglass, A. B., 450
Downs, T. D., 383
Doyle, J. M., 449
Dozois, D. A., 50, 171
Drapeau, S., 469
Dreher, A., 110

Dreyer-Oren, S. E., 308
Drossel, C., 238
Dryden, W., 308
Duarte-Velez, Y., 109
DuBois, P. H., 33
Duckworth, A., 163
Duckworth, A. L., 74, 370
Dudley, R., 211
Duffau, H., 424
Duffy, M., 379
Duke, M. C., 179
Dulcan, M. K., 114, 359
Dulgar, K., 244
Dumenci, L., 372
Duncan, B. L., 229
Dunlop, B. W., 190, 242
Dunn, M. J., 171
Dunn, T., 400
Durbin, C. E., 133
Durel, L., 407
During, E. H., 108
Dweck, C. S., 163
Dymond-Cartright, Rosalind, 283
Dysart, J., 449
Dzokoto, V. A., 506

Eagle, M. N., 261, 266
Eaker, E. D., 406
Eaves, D. E., 413

Eber, H. W., 173
Ebert, D. D., 209, 374
Eblin, J. J., 175, 180
Ebrahim, S., 409
Edmonds, E. C., 437
Edwards, A. L., 150
Edwards. J., 195
Eells, T. D., 192
Egan, K. P., 213
Egger, J., 168
Ehde, D. M., 74
Ehrenthal, J. C., 202
Einhorn, H. J., 92
Eisenberg, D., 107
Eisenberger, N. I., 401
Ekers, D., 299
Elder, K. A., 126
Elhai, J. D., 244
Eling, P., 34
Ellard, K. K., 306
Elliott, M. L., 58
Elliott, R., 283
Elliott, R. K., 272, 282
Ellis, Albert, 50–51, 302, 307–309, 376
Ellis, J. L., 7, 482, 520, 522, 533, 539
Ellis, P. D., 228
Ellis, S. J., 428
Ellsworth, J. R., 182

Elzer, M., 261
Emanuel, E. J., 60
Embry, D. D., 240, 344, 511
Emery, R. E., 469–470
Emery-Tiburcio, E., 378–379
Emmelkamp, P. M. G., 290
Emshoff, J. G., 133
Endicott, J., 114
Enescu, L., 195
Engebretson, T. O., 408
Engelhard, I. M., 297
Engels, R. C., 135
Enko, P. J., 474
Ennis, B. J., 474
Entringer, S., 398
Eonta, A. M., 341, 512
Epstein, A. M., 188
Epstein, N. B., 239, 333–334
Erbaugh, J. K., 114
Erdberg, P., 175, 179
Erickson, P. I., 113
Erickson, S. K., 469
Erickson Cornish, J. A., 495
Erikson, E., 265, 375–376
Erikson, J., 375–376
Ernst, E., 10
Eslinger, P. J., 434
Eubanks, C. F., 199

Evans, S., 193
Evans, S. W., 364, 366
Everett, A., 377
Ewbank, M. P., 196, 321
Ewing, C. P., 503
Exner, John, 175–176
Eyberg, S., 239, 335
Eyberg, S. M., 335
Eyde, L. D., 182
Eysenck, H., 172, 218, 345
Eysenck, S. B. G., 172

Fabricius, W. F., 468
Fagan, J. F., 33, 162–163
Fagan, T. J., 500
Faigman, D., 34
Fairall, J. M., 514
Fairbairn, W. R. D., 265, 268
Fairburn, C. G., 135
Fairholme, C. P., 306
Falconier, M. K., 239, 333–334
Falissard, B., 201
Fallon, T., 125
Fancher, R. E., 252–253
Fang, A., 321
Farahany, N. A., 457
Faraone, S. V., 126
Farberman, R. K., 4
Farchione, T. J., 306, 321

Farrell, L. J., 369
Farrington, D. P., 344
Fauber, R. L., 533
Faul, L. A., 410
Faust, D., 93, 245, 457, 474
Fawzy, F. I., 410
Fazel, S., 80
Fazio, R. H., 409
Fechner, Gustav, 31, 39
Fedio, P., 433
Feeley, M., 237
Feeny, N., 190
Feeny, N. C., 242
Feist, J., 402
Feisthamel, K. P., 108
Feldman, M. D., 396
Feliciano, L., 171
Feltham, C., 10
Feltner, C., 409
Fendrich, R., 433
Fenning, S., 212
Ferenczi, Sándor, 38
Ferrari, A., 514
Ferraro. K., 377
Ferrer-Garcia, M., 339
Fialova, D., 380
Field, A. P., 511
Fields, S., 336

Fincham, F. D., 511
Fine, R., 259
Finger, S., 34
Finn, S. E., 77, 87
Finney, M. L., 408
Firkowska-Mankiewicz, A., 179
First, M. B., 71–72, 114, 125, 383
Fischer, C. T., 87, 272
Fischer, M. S., 334
Fisher, J. D., 240
Fisher, J. E., 288, 290
Fisher, P., 114, 359
Fisher, S., 262
Fisher, W. A., 240
Fishman, B., 193
Fishman, D. B., 221
Fiske, D. W., 79, 84
Fitzgerald, G., 132
Fivaz-Depeursinge, E., 135
Fjeldstad, A., 262
Flanagan, D. P., 159, 179
Flannery-Schroeder, E., 366
Flay, B. R., 240, 344, 511
Fleming, M. Z., 503
Flisher, A. J., 125
Flores, A., 108–109
Flores, E., 399
Flourens, Pierre, 421

Flückiger, C., 196–197
Foa, E. B., 189, 293, 296
Fodor, J. A., 425
Folkman, S., 399–400, 406, 512
Follette, W. C., 72, 196
Folstein, M. F., 110, 442
Fonagy, P., 268
Fontenelle, G. A., 125
Forand, N. R., 193
Forbat, L., 244
Forbes, P. W., 444
Ford, D. H., 267
Ford, J. D., 244
Forehand, R., 505
Forgas, J. P., 511
Forman, E. M., 231
Foroughi, C. K., 204
Fortune, W., 452
Fossos, N., 240
Foster, G. D., 135
Foster, S. L., 130
Fotopoulou, A., 429
Fouad, N., 167
Fountain, J. W., 36
Fournier, N. M., 428
Fowers, B. J., 503
Fowler, G. A., 3–5
Frances, A., 60

Frances, A. J., 73, 125
Francis of Assisi, Saint, 316
Frank, A. F., 196
Frank. E., 133
Frank, L. K., 174
Frankel, Z., 212
Frankl, V., 272
Franklin, M. E., 296
Free, K., 194
Free, M. L., 330
Freedheim, D. K., 261
Freedman, R., 83
Freeman, A., 51, 305, 309, 315
Freeman, M. P., 347
Freeston, M., 211
French, T. M., 267
Freud, A., 252, 265
Freud, S., xxi, 38–40, 42, 45–47, 174, 202, 249–255, 258, 261–262, 264, 428
Frey, M. C., 153
Frey, W. H., 18, 503
Frick, P. J., 357, 361
Fried, E. I., 144
Fried, T. R., 380
Friederici, A. D., 428
Friedman, M., 406
Friedman-Wheeler, D. G., 330
Friedrich, P., 422
Frierson, R. L., 459

Friesen, W. V., 401
Frish, M. B., 77
Fritz, G. K., 498
Froh, J. J., 511
Frueh, B. C., 244
Fuhrer, F., 407
Fulero, S. M., 450
Fullerton, C. A., 188
Funder, D., 46
Funderburk, B. W., 239, 335
Furr, J. M., 244
Fyfe-Johnson, A. L., 347

Gaab, N., 444
Gabbard, G. O., 75, 86, 186, 212, 254, 258, 261, 267
Gabbard, K., 186
Gacy, J. W., 458
Gage, P. P., 434
Gaglio, B., 409
Gainotti, G., 428, 442
Gall, Franz, 34, 39, 420
Gallagher, D., 196
Gallo, J. J., 382–383
Gallop, R., 328–329
Galton, F., xxi, 35, 39
Gameroff, M. J., 522
Ganguli, M., 385
Gara, M. A., 108
Garb, H. N., 5, 92, 116, 125, 174, 176, 179–180, 182, 456

Garber, J., 351
Garbin, M. G., 77
Garcia-Preto, N., 336
Garcia-Rodriguez, O., 339
Gardner, H., 153, 428
Gardner, W. L., 174
Garfield, S. L., 127, 190
Garland, M. R., 347
Garlick, D., 153
Garlipp, P., 506
Garner, P., 414
Garrison-Diehn, C., 288
Garske, J. P., 195
Garth, M. H., 409
Gasquoine, P. G., 498–499
Gastelum, E., 58, 258
Gaston, L., 196
Gates, M. A., 514
Gathright, M., 107
Gatz, M., 375, 377
Gatzke-Koop, L., 373
Gaudiano, B. A., 234
Gay, P., 252
Gazzaniga, M. S., 433
Gazzillo, F., 211
Geer, J. H., 171
Geffner, R., 469
Geher, G., 153

Gehrman, P. R., 331
Geisinger, K. F., 41, 144, 171
Gelfand, D. M., 351
Gendreau, P., 467
Gentile, D. A., 4, 186
Geraghty, A. W. A., 511
Gerbarg, P. L., 348
Gerber, G., 268
Gerger, H., 241
Gerin, W., 407
Gerlach, A., 261
Gersztenkorn, D., 431
Gewirtz-Meydan, A., 387
Ghacibeh, G. A., 428
Ghaed, S. G., 388
Gharagozloo, L., 245
Ghin, H. L., 413
Gianaros, P. J., 408
Giang, K. W., 399
Gibbons, A., 237
Gibbons, M. B. C., 196, 328–329
Gibson, J. M., 511
Gilhooly, K. J., 388
Gillberg, C., 140
Gillis, J. R., 126
Gillis, R. D., 132
Ginger, A., 281
Ginger, S., 281

Ginter, R., 15
Giordano, J., 336
Giovannucci, E. L., 382
Gizer, I. R., 373
Glad, J., 132
Glaser, R., 179, 398, 403
Glasgow, R. E., 346, 409
Glass, C. R., 58, 204, 510
Glass, G. V., xxii, 228
Glenn, T., 126
Glesser, G. C., 85
Glosser, G., 433
Glozman, J. M., 425
Glueckauf, R., 338
Glueckauf, R. L., 338, 512
Goddard, Henry, 154
Goins, M. K., 125
Gold, J., 24, 57, 125, 510
Goldberg, E., 425, 435
Goldberg, L. R., 91
Goldberg, S. B., 191, 213
Golden, C. J., 439
Goldfarb, L. P., 150
Goldfried, M. R., 58, 68, 117, 244, 298, 510
Goldin, P. R., 317, 330
Golding, S. L., 92
Goldman, R. N., 283
Goldsmith, J. B., 135

Goldstein, A., 474
Goldstein, B. L., 298
Goldstein, G., 439
Goldstein, K., 425
Goldstein, M. G., 416
Goldstein, S., 152
Goleman, D., 474
Golub, S. A., 411
Gómez Penedo, J. M., 213
Gomez, G. S., 135–136
Gone, J. P., 18
González, J. M., 110
Gonzalez-Prendes, A. A., 508
Gooblar, J., 378–379
Goode, J., 212
Goodheart, C. D., 23, 498
Goodson, J. T., 512
Gorman, J. M., 242, 244
Gorsch, E., 244
Gorske, T. T., 87
Gotlib, I. H., 304
Gottdiener, W. H., 452–453
Gottfredson, L. S., 152
Gottman, J. M., 135, 239, 336
Gough, H., 173
Goyer, J. P., 204
Gralnick, T. M., 171
Granholm, E., 298

Granic, I., 135
Grann, M., 80
Graver, R., 506
Graves, C. C., 489
Graves, T. A., 197
Grawe, K., 190, 204
Green, A. E., 245
Greenberg, L. S., 191, 196
Greenberg, R. P., 191–192, 212, 236, 262
Greene, B., 107
Greene, C. J., 331
Greene, E., 449, 452
Greene, R., 132
Greene, R. L., 174
Greenhoot, A. F., 220, 223
Greenhouse, S., 377
Greening, T., 272
Greenway, D. E., 72
Greiner, L. H., 401
Grewal, S., 107, 110, 125
Grey, M. J., 373
Griffen, P., 376
Griffiths, M. D., 374
Grigorenko, E. L., 163
Grilo, C. M., 126, 241
Grimes, K. E., 134
Griner, D., 506
Grisso, T., 451, 463

Grodzinsky, G. M., 444
Gronlund, S. D., 449
Gros, D. F., 321
Gross, B. H., 465
Gross, J. J., 317
Grossman, S., 179
Groth-Marnat, G., 65, 70, 87, 116, 139, 144, 159, 171, 173, 179, 190, 211
Grotz, R. C., 383
Grove, W. M., 22, 91, 93–94, 115, 456, 467
Grubaugh, A. L., 244
Gruber, N., 180
Gruen, R. J., 400
Gruenewald, T. L., 401
Grus, C. L., 483–485, 488
Grydeland, H., 433
Gu, J., 317
Guan, M., 165
Guarnaccia, P. J., 88, 100
Guevremont, D. C., 288–290
Gulec, H., 339
Gum, A. M., 380
Gunderson, J. G., 196
Gunter, R. W., 297
Guo-Peng, C., 181
Gur, R. E., 443
Gurman, A. S., 187, 231, 239
Gurung, R. A. R., 396
Gushue, G. V., 109

Gustad, J. W., 479
Gustafsson, C., 132
Gustafsson, J. E., 153
Gutierrez-Maldonado, J., 339
Guyton, M. R., 449

Haas, J. S., 382
Habben, C. J., 488
Hackney, H., 190, 192
Hadjistavropoulos, T., 129, 132
Hage, M. P., 382
Haglin, D., 193
Hagmayer, Y., 108–109
Hagtvet, K., 202
Haier, R. J., 153
Hajal, N. J., 373
Hale, M., 77
Haley, J., 335
Halfon, S., 198
Hall, D., 458
Hall, G. C. N., 19, 72, 79, 505–506
Hall, G. S., 38
Hall, J. E., 488, 512
Hall, S. E., 373
Hall, S. R., 7
Hallahan, B., 347
Hallion, L. S., 308, 340
Halperin, L., 105, 198
Halsted, W., 422

Hambleton, R. K., 181
Hamilton, J. D., 244
Hamilton, K. E., 223
Hamm, M. P., 374
Hammeke, T. A., 439
Hammond, K. R., 97
Hammontree, S. R., 176
Hamp, A., 12, 16
Han, S. S., 227
Handler, L., 150
Hansen, J. A., 212
Hanson, R. K., 91, 93
Hanson, W. E., 77
Harbeck, C., 135
Harding, T. P., 95
Hare, R. D., 114
Harel, G., 212
Harkness, K. L., 52, 399
Harlow, J. M., 434
Haro, J. M., 131
Harrington, C. B., 325
Harrington, D., 382
Harris, B., 48
Harris, G. T., 80, 93
Harris, K. R., 321
Harris, R., 331
Harris, Russ, 319
Harrower, M. R., 174

Harsinay, A., 109
Hart, B., 522
Hart, C. A., 399
Hart, S., 458
Hart, S. D., 80
Hartmann, H., 265
Harvey, A. G., 321
Harvey, E. A., 113
Harway, M., 332
Harwood, T. M., 28, 65, 70, 113, 139, 144, 171, 189–190, 198, 200, 211, 240, 346–347, 512
Haslam, N., 72
Hatcher, R. L., 485
Hatfield, D. R., 15
Hathaway, Starke, 168
Haug, T., 347
Hausmann, M., 428
Havens, L., 119
Havik, O. E., 347
Hawes, D. J., 135
Hawley, K. M., 228, 364–366
Hayden, E. P., 52
Hayes, A. F., 467
Hayes, A. M., 244
Hayes, J. A., 506
Hayes, S. C., 25, 58–59, 233, 316–318
Haynes, S. N., 77, 125, 132–133
Haynos, A. F., 344

Hays, D. G., 70
Hazlett-Stevens, H., 202, 242, 291–292, 410
Heal, L. W., 126
Healy, William, xxi
Hearon, B., 196
Hedges, M., 58
Hedman-Lagerlöf, E., 338
Heiby, E. M., 27, 198, 501
Heidegger, M., 281
Heidenreich, T., 514
Heider, F., 305
Heilbrun, K., 449, 452–453, 474
Heilman, K. M., 419, 428
Heimbert, R. G., 321
Heinonen, E., 191
Heller, M., 496
Heller, W., 443
Hellige, J. B., 423
Helmholtz, H., 31, 39
Helms, J. E., 162, 506
Hendrie, H. C., 113
Hendriks, M., 446
Henggeler, S. W., 239, 335
Henke, C. J., 396
Henri, Victor, 35
Henry, G. W., 37, 176
Henry, W. E., 176
Herbert, 244

Herbert, J. D., 231
Herink, R., 187
Herrington, J. D., 442
Herrnstein, R. J., 162
Hersch, P. D., 462
Hersen, M., 102, 135, 171, 221, 234, 290, 510
Hester, R. D., 514
Hetherington, E. M., 469
Heyman, R. E., 134, 139
Hezlett, S. A., 527
Hibbeln, J. R., 347
Hickman, L. D., 380
Hilgard, E. R., 38
Hill, C. E., 190, 212
Hillier, L. M., 512
Hilsenroth, M. J., 212
Hilton, N. Z., 80, 93
Himelein, M. J., 483
Himmelhoch, J. M., 135
Hinckley, John, 457–458
Hindo, C., 508
Hinkley, J. W., 144
Hinrichsen, G., 378–379
Hinrichsen, G. A., 379
Hinshaw, S. P., 354, 511
Hinton, D., 506
Hinze, E., 254
Hippocrates, 36

Hobaica, S., 548
Hoeft, F., 444
Hoestring, R., 181
Hoffer, L. J., 179
Hoffman, L. J., 474
Hofmann, S. G., 25, 58–59, 233, 316–317, 321
Hogan, J., 85
Hogarth, R. M., 92
Hoge, C. W., 106
Hoge, S. K., 451, 453, 463
Høglend, P., 202
Holden, J., 298
Holden, R. R., 133
Holland, E., 72
Holland, J. L., 165, 259
Holland, J. M., 212, 388
Hollanders, H., 58
Holling, H., 239
Hollingworth, L. S., 43
Hollon, S. D., 58, 223, 241, 313, 321
Holman, J., 198
Holmboe, E. S., 133
Holmes, J., 458
Holmes, J. M., 338
Holmes, T. H., 399
Holt, R. R., 79
Holtforth, M. G., 190
Homant, R., 466

Hong, J. J., 317
Hong, N., 77
Honigfeld, G., 132
Hood, H. V., 411
Hooper, L., 364
Hope, D. A., 135
Hopwood, C. J., 74
Hornstein, E. A., 401
Horowitz, M., 186
Horowitz, M. J., 202
Horst, K., 198
Horvath, A. O., 196–197, 236–237
Horwitz, A. V., 61
Hough, L., 150
Hough, S., 503
Houts, A. C., 72
Howard, K. I., 196, 204
Howe. L. C., 204
Howieson, D. B., 425, 440
Hsieh, D. K., 125
Hsu, L. K., 110
Hsueh, L., 548
Huang, E. R., 79
Huber, J., 202
Hudomiet, P., 387
Huey, S. J., 371–373, 506
Huey, S. J., Jr., 505
Hufford, C., 125

Huibers, M. J., 209, 236, 321
Hummelen, B., 106
Hundt, N. E., 79
Hunsley, J., 68, 357, 360
Hunsley, J. D., 77, 125
Hunt, A., 382
Hunt, J. B., 107
Hunt, M., 218
Hunter, S. J., 446
Huprich, S. K., 74
Hurd, M. D., 387
Hurd, N. M., 528
Hutchinson, S., 126
Hwang, 506
Hy, L., 177
Hybels, C. F., 382–383
Hyman, 71

Ibaraki, A. Y., 79
Igarashi, H., 376
Ilut, S., 442
Imel, Z. E., 76, 236–237, 507
Ingham, B., 211
Innoue-Choi, M., 396
Insel, T. R., 61, 75
Inskipp, F., 190
Inui, T., 414
Irfan, N., 195
Ironson, G., 404

Irwin, H. J., 467
Isaacs, K., 400
Iskandarsyah, A., 107
Ivanova, M. Y., 372
Iverson, D. J., 437
Ivey, G., 25
Iwamasa, G. Y., 108
Iwata, B. A., 129, 288

Jackson, D. D., 335
Jackson, D. N., 150
Jackson, J. H., 425
Jackson, Y., 352
Jacobsen, P. B., 410
Jacobson, E., 291
Jacobson, N. S., 218
Jacoby, A. M., 483
Jacoby, L. L., 433
Jaffee, S. R., 261
James, W., 38, 40
Jamieson, D., 4
Janet, Pierre, 38–39
Jaser, S. S., 400
Jay, S., 413
Jaycox, L., 462
Jefferson, K. W., 411
Jeffries, J. C., Jr., 457
Jenkins, C. M., 338
Jenkins, S., 107, 110, 125

Jenkins, W. O., 120
Jenkinson, P. M., 428
Jennings, L., 190, 192, 202
Jennissen, S., 46, 202–203
Jensen, A. R., 152
Jensen, P. S., 373
Jensen-Doss, A., 92, 192, 228, 317
Jergeby, U., 132
Jeste, D. V., 387
Jia, M., 374
Jiang, Y. V., 433
Jia-xi, C., 181
Jiménez-Chafey, M. I., 505
Jin, R., 188
Johansson, U., 140
Johnson, J., 500
Johnson, J. C., 245
Johnson, J. E., 328–329
Johnson, M. D., 133
Johnson, S. M., 5, 182, 239
Johnson, W., 153
Johnson, W. B., 492
Johnson-Greene, D., 441
Johnston, D. W., 407
Johnstone, T., 307
Jones, B. P., 422, 439
Jones, D. L., 331
Jones, E., 38

Jones, E. B., 340
Jones, E. E., 109, 202
Jones, M. C., xxi, 48–49, 137
Jones, N. T., 132
Jones, P. J., 364
Jonson, J. L., 41, 144, 171
Joormann, J., 304
Jordan, J. R., 133
Jorm, A. F., 345, 347, 513
Josefsson, T., 415
Joseph, S., 74
Jouriles, E. N., 133, 135–136
Jung, C., 38, 41, 173, 265, 268
Jung, R. E., 153

Kächele, H., 261
Kaczorowski, J. A., 110, 514
Kagan, J., 373
Kahn, E., 266
Kahn, J. H., 236
Kahn, R. L., 429
Kahneman, D., 92, 94
Kales, H. C., 109
Kalichman, S. C., 411
Kamarck, T., 399
Kambeitz, J., 52
Kamphaus, R. W., 159, 357, 361
Kane, L., 9, 27
Kang, S., 297

Kannel, W. B., 406
Kantamneni, N., 167
Kantor, E. D., 382
Kapardis, A., 469
Kaplan, A., 58
Kaplan, C. P., 113
Kaplan, J. R., 404
Kaplan, S. A., 4, 186
Kaplan, S. J., 79
Karel, M. J., 375, 377, 379
Karg, R. S., 58, 114, 383
Karlin, B. E., 233
Karna, A., 369
Karnes, F. A., 164
Karol, D., 173
Karow, A., 242
Karpiak, C. P., 315, 323, 539
Karterud, S., 106
Karver, M. S., 236
Kashdan, T. B., 401
Kaslow, F. W., 239–240, 332, 336, 355
Kaslow, N. J., 72, 332, 484, 489
Katz, S., 383
Kaufman, A. S., 159, 161
Kaufman, N. L., 159, 161
Kausel, E. E., 127
Kawachi, I., 400
Kazak, A. E., 373

Kazantzis, N., 194, 196, 203
Kazdin, A. E., 13, 23, 27, 59, 61, 77–78, 213, 219, 221, 237, 324–326, 335, 459, 514
Keane, M. M., 433
Keefe, F. J., 409
Keefe, J. R., 229
Keilin, W. G., 468
Keller, M. B., 109, 115
Kelley, C. M., 433
Kelley, D. M., 174
Kelley, J. E., 401
Kelley, M. P., 443
Kelly, E. L., 79
Kelly, G., 49–50
Kelly, G. A., 173
Kelly, J. A., 411
Kelly, J. R., 133
Kemeny, M. E., 401
Kemp, I. A., 152
Kemper, S. J., 401
Kendall, P. C., 219, 223, 234, 243–244, 366, 374
Kendler, K. S., 37, 52
Kennedy, D. B., 466
Kennedy, P. J., 498
Kenyon, A. D., 315
Kenyon, A. G., 234
Kerig, P. K., 336
Kern, J. M., 135

Kernberg, O., 265
Kerr, S. M., 413
Kerridge, B. T., 188
Kessler, E.-M., 381
Kessler, R., 347
Kessler, R. C., 19, 188, 324, 399, 402
Ketterson, T. U., 338
Khalis, A., 374
Khanna, C., 15
Khanna, M. S., 374
Khoshaba, D. M., 406
Kiecolt-Glaser, J. K., 398, 403, 408
Kierkegaard, S., 281
Kieth-Spiegel, P., 193
Kihlstrom, J. F., 61, 261–262
Kim, B. H., 150
Kim, J., 190
Kim, J. M., 18
Kim, S. C., 196
Kinge, J. M., 405
Kinnaman, J. E. S., 298
Kinnebrook, David, 33
Kinscherff, R., 492
Kirby, J. S., 239, 333–334
Kirk, S. A., 125
Kirkley, D. E., 331
Kirkpatrick, H. A., 373
Kister, K. M., 25

Kitamura, T., 408
Kitayama, S., 408
Kivlighan, D. M., III, 213, 229
Klainin-Yobas, P., 292
Kleespies, P. M., 106, 194
Kleijnen, J., 140, 233
Kleiman, E. M., 406
Klein, G., 92, 94
Klein, M., 265, 268
Kleinmuntz, B., 92
Kleinstäuber, M., 182
Klepac, R. K., 500
Klerman, G., 269
Klett, C. J., 132
Klonoff, E. A., 481, 483
Klonsky, E. D., 231
Klopfer, B., 174
Klopfer, W. G., 99
Knapp, S. J., 492–493, 495–496
Knekt, P., 191
Knight, B., 388
Knight, B. G., 379
Knox, S., 212
Kochanek, K., 375
Kocsis, R. N., 467
Koerner, K., 320
Koester, K. A., 411
Koffel, E. A., 331

Kohlenberg, R. J., 196
Kohn, R., 324
Kohout, J., 480, 522
Kohout, J. L., 482
Kohrt, B., 342
Kohrt, B. A., 343
Kohut, H., 265
Kok, R. N., 340
Kolb, B., 441
Kolko, D., 211
Komiti, A. A., 126
Koocher, G. P., 355
Koole, S. J., 241
Koole, S. L., 209, 241
Koonce, D. A., 108
Kopel, S. A., 133
Kopelman, R. E., 165
Kopta, M., 192
Korchin, S. J., 4, 38
Koretz, D., 162
Korman, M., 24, 479
Korschgen, A. J., 517, 527, 539–540
Kotchick, B. A., 505
Kotov, R., 61, 74
Kotz, S. A., 428
Kovacs, M., 357
Krackow, E., 348
Kraepelin, E., 37, 39, 61

Krafft-Ebing, R. von, 38
Kramer, P. D., 268
Krantz, D., 407
Krantz, D. S., 404, 406
Krasnow, A. D., 244
Kraus, D. R., 133
Kreuzpointner, L., 180
Krieger, T., 190
Krishnamurthy, R., 88
Krol, N., 92
Krug, O. T., 281–282
Kruse, A., 381
Kubzansky, L., 400
Kubzansky, L. D., 407
Kuersten-Hogan, R., 471
Kuhlman, K. R., 408
Kulic, K. R., 113
Kulkarni, G., 387
Kumpfer, K. L., 240
Kuncel, N. R., 527
Kunen, S., 108
Kuppens, P., 72
Kuppens, S., 364
Kurtz, S. M. S., 132
Kurtzman, H., 22
Kwate, N. O. A., 162

La Roche, M. J., 234
Laaksonen, M., 191

L’Abate, L., 30, 240, 346

Labbe, A. K., 344

Lachs, M. S., 383

Ladavas, E., 429

Ladd, P. D., 281

Lagay, F., 464

LaGreca, A. M., 234, 364

Lah, M. I., 360

Lake, J., 347

Lam, K. C., 203

Lambert, D., 88, 498

Lambert, M. J., 14, 27, 76, 182, 196, 198, 227–228, 234–235, 237

Lancaster, C. J., 125

Landerman, L. R., 382

Landes, S. J., 320

Lang, P. J., 137

Lang, S., 140

Lange, A., 239

Langer, D. A., 244

Langer, K. G., 431

Längle, A., 47

Langton, C. M., 79

Lanik, M., 110

Lapatin, S., 373

Laplanche, J., 264

Larner, A. J., 129

Larrabee, G. J., 439

Larsen, H., 135

Larson, J., 503
Larson, K. L., 348
Lashley, K., 421, 425
Laska, K. M., 231
Latham, R. M., 132
Latimer, C. S., 401
Latzman, R. D., 235
Lau, Y., 292
Lavik, K. O., 198
Lavretsky, H., 387
Lawlis, G. F., 171
Lawrence, E., 332
Lawton, M. P., 383
Layard, R., 28, 59, 326
Layzer, C., 409
Lazarides, C., 398
Lazarus, A. A., 211
Lazarus, R. S., 307, 399–400, 406, 512
Lazovik, A. D., 137
Le, Q., 190
Leahy, R., 321
Lean, D., 360–361
Leary, M. R., 306, 401–402
Leavitt, R., 161
Lebow, B. S., 91, 93, 467
Lebow, J. L., 510
Lebowitz, B. D., 388
Ledley, D. R., 321

Lee, A. C. H., 387, 433
Lee, A. G., 431
Lee, C. M., 240, 360
Lee, D. S., 403
Lee, I.-C., 387
Leech, S., 87
Legha, R. K., 245
Lehman, D. R., 403
Lehmann, M. E., 203
Lei, H., 224
Leibovich, L., 236
Leichsenring, F., 228
Leisen, J. C. C., 401
Lenore, S., 113
Lenze, S., 335
Leon, K., 360
Leon, S. C., 191
Leonardo da Vinci, 174
Leong, F. L., 169
Leong, G. B., 495
Lepore, S. J., 407
Lerman, D. C., 129
Lerner, H., 266
Leszcz, M., 328, 330
Levant, R. F., 22, 512–513
Levav, I., 324
Levenson, R. W., 234, 315, 484
Levin, M. E., 317–318

Levine, E. S., 500
Levison, H., 268
Levy, B. R., 387
Levy, D., 174
Lew, H. L., 136, 140
Lewis, C. C., 192
Lewis, G., 92
Lewis, M. A., 240
Lewis-Fernández, R., 108–109
Ley, P., 413
Leykin, Y., 344, 511
Lezak, M. D., 425, 440, 447
Li, A., 84
Li, S. T., 107, 110, 125
Lichner, T. K., 293
Lichstein, K. L., 388
Lichtenberg, P. A., 388
Lichtenstein, E., 133
Lidz, R. W., 335
Lidz, T., 335
Liese, B. S., 330
Lilienfeld, S. O., 4–5, 13, 20, 59, 61, 70, 75, 92, 116, 121, 150, 176, 179, 186, 223, 233, 235, 240, 262, 281, 347–348, 456, 458, 469
Lillesand, D. B., 135
Lima, E. N., 182
Lin, J. S., 409
Lin, L., 3, 12, 16, 18
Lin, Y.-J., 213

Linda, W. P., 500
Lindahl, K. M., 336
Lindfors, O., 191
Lindhiem, O., 211
Lindsley, O. R., 49
Lindwal, M., 415
Lindzey, G., 165, 176
Linehan, M. M., 290, 308, 320
Lingiardi, V., 74
Link, P. C., 298
Linnan, L. A., 325
Lints-Martindale, A. C., 129, 132
Lipgar, R. M., 175
Lipp, O. V., 338
Lippens, T., 227
Litowitz, B. E., 75
Littleford, L. N., 5
Litwack, T. R., 474
Liu, E. T., 217
Livingston, G., 336
Lix, L. M., 129, 132
Lizardi, D., 506
Llera, S. J., 347
Llobera, J., 136
Lloyd, D. A., 108
Locher, C., 367
Lochman, J. E., 234, 240, 364
Lock, T., 348

Lockard, A. J., 110
Locke, B. D., 506
Loevinger, J., 83, 177, 261
Loftus, E. F., 348, 449
Lohr, J. M., 186
London, S., 245
Long, J. K., 332
Looman, J., 136
Loomis, J. S., 338
López, C. M., 338
Lopez, S., 74
Lopez, S. R., 18, 88, 100
Lopez-Duran, N. L., 52
Loprinzi, P. D., 396
Lorandos, D., 474
Loranger, A. W., 114
Lorch, M., 422
Lorentzen, S., 262
Loring, D. W., 425, 439–440
Lorzano, C., 126
Loughner, Jared Lee, 451
Lovejoy, D. W., 446
Low, P. W., 457
Lu, L., 107
Lubinski, D., 153
Luborsky, L., 79, 191, 196, 229
Luby, J., 335
Luby, J. L., 52

Lucas, C. P., 114, 359
Lueger, R. J., 204
Luft, A. R., 441
Luhrmann, T. M., 60
Lumley, M. A., 401
Lund, C., 125
Lundgren, T., 319
Lunt, I., 488
Lunt, I. T. I., 43
Luria, A., 424–425, 439
Luzzati, C., 432
Lynch, C. A., 162
Lynch, F. L., 242, 347
Lynch, K., 224
Lynch, M. F., 190
Lynch, P. S., 162
Lyneham, J. J., 113
Lynham, D. R., 116
Lynn, R., 162
Lynn, S. J., 92, 186, 235, 348, 458
Lyon, P. M., 449

Macdonald, H., 88
Machado, P., 113, 344
Machado, P. P. P., 190–191
Machover, K., 177
Mackenzie, C. S., 227, 388
MacKenzie, K. R., 328
Mackinnon, A. J., 347

MacKinnon, R. A., 102, 104
Macklin, D. S., 462
MacLeod, C., 308, 340
MacNeil-Vroomen, J., 402
Maddi, S. R., 406
Madrid, H. P., 127
Magnin, E., 441
Maguen, S., 514
Mahler, M., 265, 268
Mahoney, 51
Maiberger, P., 442
Maier, J. A., 186
Mains, J. A., 347
Mair, P., 364
Maislen, A., 495
Maisto, S. A., 92, 344
Makover, R. B., 210
Makovski, T., 433
Malarkey, W. B., 403
Malessa, R., 420, 424
Malgady, R. G., 100
Malik, M. L., 76
Maling, M. S., 204
Malone, P. S., 374
Maloney, M. P., 148
Malony, H. N., 505
Manchak, S., 81
Mandelid, L. J., 228

Mann, T., 413
Manuck, S. B., 404
March, S., 338
Marchette, L. K., 59
Marcus Aurelius, Emperor, 316
Marcus, D. K., 150
Marcus, D. R., 449
Marcus, S. C., 28, 189
Marczyk, G., 474
Marecek, J., 26
Marengoni, A., 380
Margolin, G., 239
Margraf, J., 115, 224
Marin, R. S., 435
Marini, A., 427
Marinkovic, K., 427
Markesbery, W. R., 401
Markman, H. J., 135
Markowitz, J., 411
Markowitz, J. C., 269
Markus, E., 239
Marlatt, G. A., 135
Marmar, C., 196
Marmot, M., 407
Marsh, H. W., 144
Marshal, N., 444
Marshall, E., 197
Marshall, N., 113

Marshall, W. L., 136
Marti, C. N., 79, 344
Martin, D. J., 195
Martin, P. R., 519
Martin, R., 125
Martinez, M., 164
Martinko, M. J., 174
Martino, S., 191, 199
Martinovich, Z., 204
Martz, D. M., 125
Marx, B. P., 321
Marx, J. A., 203
Marziali, E., 196
Maselko, J., 400
Mash, E. J., 68, 130, 159, 179, 182, 357
Masheb, R. M., 241
Maskelyne, N., 33
Maslow, A. H., 281
Massot-Tarrús, A., 427
Masten, A. S., 352, 370, 400, 512
Masters, K. S., 512
Matarazzo, J. D., 102, 446
Matarazzo, R. G., 335
Matesky, G., 466
Mathbout, M., 494
Mather, A., 388
Mather, N., 360
Mathews, A., 308, 340

Matthews, J. R., 487–488
Matthews, K., 405
Matthews, K. A., 406
Matthews, L. H., 487–488
Mauler, B., 190
Maxwell, H., 198
May, D. J., 113
May, R., 272
Mayer, J. D., 153
Mayes, R., 61
Mayne, T. J., 522–523
Mayo-Wilson, E., 230
Mays, K. L., 159
Mays, V. M., 505
McAleavey, A. A., 203, 506
McArthur, D. S., 177
McCabe, R. E., 328, 330
McCallum, K., 116
McCandliss, B. D., 444
McCann, J. T., 503
McCann, R. A., 514
McCarthy, K. S., 197
McCarty, C. A., 229
McCeney, M. K., 406
McClelland, M., 458
McClendon, D. T., 329
McConaughy, S. H., 133, 359
McConnell, K. J., 498

McCoy, S. A., 92
McCrae, R. R., 167, 179
McCusker, J., 126
McCutcheon, S. R., 483–485, 533
McDaniel, S. H., 336
McDonald, R., 135–136
McDonald, S. D., 382
McDonald-Scott, P., 115
McFall, R. M., xxii, 5, 22–24, 60, 135, 481–483, 510
McGaugh, J. L., 433
McGill, A. C., 132
McGinn, M. M., 239, 510
McGoldrick, M., 336
McGowan, A. S., 281
McGrady, A., 395, 402
McGrath, R. E., 150, 500–501
McGrew, K. S., 360
McGuire, T. G., 188
McGurk, D., 106, 344
McHale, J. P., 336
McHugh, P. R., 442
McHugh, R., 188
McHugh, R. K., 513
McIntyre, K., 133
McKay, D., 59, 223, 231
McKay, J. R., 113
McKinley, J. C., 168
McKown, D. M., 159

McLean, C. P., 189
McLennan, J., 58
McLeod, B. D., 244, 317
McLeod, J., 58
McMahon, S. A., 454
McMinn, M. R., 194
McNally, R. J., 308
McNamara, J. R., 4, 186
McNulty, J. K., 511
McQuaid, J. R., 298
McQuown, C. K., 388
McReynolds, P., 32–33, 65
McTeague, L. M., 52
McWilliams, N., 74
Mead, M., 132
Meador, B. D., 273
Medeiros, G. C., 110
Mednick, S. C., 433
Medsker, G. J., 15
Meehl, P. E., 22, 83, 91, 93, 99, 262, 467
Meeks, T. W., 387
Meichenbaum, D. H., 302
Meissner, W. W., 196
Melchert, T. P., 58
Melham, N. M., 81
Melton, A. W., 134
Meltzer, H., 113
Mendel, R. R., 34

Mendelson, M., 114
Menne-Lothmann, C., 308, 340
Mens, M. G., 410
Merckelbach, H., 150
Merenda, P. F., 181
Merrill, B. M., 190
Mermelstein, R., 133, 399
Merz, C. C., 392
Merz, J., 241–242
Messenger, L. C., 483
Messer, L., 503
Messer, S., 190, 192
Messer, S. B., 187
Messick, S., 83
Mesulam, M. M., 426
Meyer, B., 483
Meyer, G. J., 74, 175, 180
Meyer-Lindenberg, A., 443
Meyers, J. E., 385
Meyers, K. R., 385
Meyers, L., 499
Meynen, G., 457
Michael, K. D., 331
Michalak, J., 514
Michalski, D., 522
Michalski, D. S., 3–5
Michelow, D., 428
Michels, R., 102, 104

Michelson, A., 198
Mihalopoulos, C., 343
Mihara, R., 503
Mihura, J. L., 179
Mikami, A. Y., 374
Milam, J., 347
Milich, R., 132
Miller, A., 28, 200, 242
Miller, A. B., 105, 200
Miller, A. L., 290, 308
Miller, E., 344
Miller, G., 73, 414
Miller, G. A., 446
Miller, G. E., 401
Miller, I. W., 234
Miller, J. D., 116
Miller, K., 211
Miller, M. L., 503
Miller, M. O., 7, 153
Miller, S. D., 192
Miller, T. I., xxii, 228
Miller, T. Q., 406
Miller, W. R., 347, 512
Millon, T., 179
Millon. C., 179
Milman, D., 201
Milner, B., 426, 433
Milner, D. A., 433

Miloff, A., 292
Miltenberger, R. G., 129, 221
Miniscalco, C., 140
Miniussi, C., 441
Miraglia, R., 458
Mirandez, R. M., 437
Mirsattari, S. M., 427
Misca, G., 471
Mischel, W., 97, 302
Mishkin, M., 431
Misovich, S. J., 240
Mitchell, A. J., 442
Mitchell, C. M., 133
Mitchell, M., 150
Mitchell, M. J., 88
Mitchell, R. L., 443
Mitchell-Gibbons, A., 110
Mittal, V. A., 292
Mizock, L., 503
M'Naughton, D., 454, 458
Mock, J. E., 114
Moffitt, T. E., 10, 261, 373
Mograbi, D. C., 429
Moher, D., 224
Mohr, D., 113
Moitra, E., 109
Molina, B. S., 366, 368
Molinari, V., 379

Molinari, V. A., 378–379
Monahan, J., 450, 453, 463
Monroe, S. M., 399
Montgomery, G. H., 331
Montross, C., 458, 460
Moon, Z., 413
Moore, B. V., 479
Moore, T. E., 346
Morales, E., 234
Morales, E. S., 505
Moran, P., 320
Moreno, J., 135
Moretti, R. J., 179
Morey, L., 92
Morgan, A. J., 347
Morgan, B. L., 460, 517, 527, 539–540
Morgan, C. D., 176
Morgenstern, J., 223
Morland, K., 405
Morris, R. G., 429
Morrison, A. P., 242
Morrison, C. S., 126
Morrow, C. E., 514
Morse, C. J., 106
Morse, S. J., 474
Mortamais, M., 437
Mortimer, J. A., 401
Morton, A., 105

Morton-Bourgon, K. E., 91, 93
Moseley, G. L., 410
Moskowitz, J. T., 512
Moss, D., 395, 402
Möttus, R., 167, 407
Mousavi, S. R., 427
Moyer, V. A., 387
Mrozcek, D., 376
Mueller, A. E., 103, 113, 115
Muenz, L. R., 125
Muessig, K. E., 411
Muir, H. J., 77
Mullan, J., 387
Müller, Johannes, 31, 39
Muller, K. L., 221
Mulvey, E. P., 81
Munder, T., 228
Muñoz, R. F., 338
Munsey, C., 494, 498, 500, 532
Muran, J. C., 199
Murdock, N. L., 194–195, 254, 290
Murphy, D., 195
Murphy, D. A., 411
Murphy, J. G., 224–225
Murphy, M. J., 512
Murphy, S., 375
Murphy, S. A., 224
Murphy-Brennan, M., 369

Murray, C., 162
Murray, D. W., 374
Murray, H., 79, 176
Murray, L. K., 343
Murrie, D. C., 81
Murstein, B. I., 179
Murthy, V., 465
Muskin, P. R., 348
Mussen, P. H., 150
Muthén, B. O., 382
Myers, D. G., 400, 402
Myers, I. B., 173
Myklebust, H. R., 444

Na, J. J., 374
Nagendra, A., 108
Naglieri, J. A., 152
Nagy, T. F., 205, 207, 492–494
Nahum-Shani, I., 224
Najavits, L. M., 125
Najolia, G. M., 109
Najt, P., 428
Nakano, K., 408
Nakash, O., 105, 127, 198
Nanayakkara, N., 401
Napili, A., 378
Narayan, A. J., 400
Nasar, J. L., 199
Nasreddine, Z. S., 385

Nathan, J. S., 144

Nathan, P. E., 244

Naugle, A. E., 196

Navon, D., 432

Neacsiu, A. D., 320

Neale, J. M., 399

Neighbors, C., 240

Neimeyer, G. J., 488

Neimeyer, R. A., 388

Neisser, U., 162

Nelson, C., 91, 93, 467

Nelson, C. A., 254

Nelson, M., 109

Nelson, P. T., 436

Nesi, J., 374

Ness, L., 110

Neufeldt, S. A., 190

Nevid, J. S., 107

Nevo, B., 148

Newman, C. F., 289, 306, 321

Newman, M. G., 347

Neylan, T. C., 434

Nezworksi, M. T., 179

Nich, C., 191, 199

Nichols, M. P., 336

Nichols, R. C., 173

Nicholson, A., 407

Nicholson, R. A., 469

Nickerson, R. S., 57, 92, 125
Niebuhr, R., 316
Niederehe, G., 388
Nielsen, A. S., 209
Nielsen, L., 469
Nielsen, S. L., 105
Nienhuis, F., 113
Nienhuis, J. B., 196
Nietzel, M., 452
Nietzel, M. T., 68, 135, 138–139
Nietzsche, F., 281
Nigg, J., 366
Niogi, S. N., 444
Nissen-Lie, H. A., 191
Nitschke, J. B., 443
Noazin, S., 240
Nocentini, U., 427
Nock, M. K., 132, 188, 221
Noguchi, T., 465
Nolen-Hoeksema, S., 58
Norcross, J. C., 7–8, 21, 58, 76, 105, 194–196, 198, 211–212, 234–237, 240, 244, 261, 268, 315, 323, 346–347, 482, 510, 520, 522–523, 525, 527, 532–533, 535–537, 539–540, 543, 547
Nordal, K. C., 27
Nordgreen, T., 347
Normand, S. T., 188
Norton, P. J., 135, 321
Notarius, C., 135

Novak, M., 399
Novins, D. K., 245
Novotny, C. M., 232
Núñez, C., 443
Nuñez, M., 292
Nurius, P. S., 102
Nurse, A. R., 470
Nysse, K. L., 542

O'Donohue, W., 5
O'Malley, S. S., 196
Oakes, H. J., 446
O'Bannon, R. E., 411
Oberjohn, K., 339, 374
Oberman, L. M., 511
O'Brien, G. T., 139
O'Connell, D., 150
O'Donohue, W., 506
O'Donohue, W. T., 344, 469
Oei, T. P. S., 330
Ogilvie, J., 244
Ogles, B. M., 15
Ogloff, J. R. P., 466
Oh, D., 316
O'Hara, P., 377
O'Hearn, T., 316
Olarte, S., 267–268
Olbert, C. M., 108
O'Leary, K. D, 133

Olfson, M., 10, 28, 189, 382
Olivas, J. C., 378
Olive, H., 98
Oliver, P. H., 239
Oliver, P. J., 179
Olivera, J., 213
Ollendick, T. H., 22, 59, 132, 231, 369
Onder, G., 380
O'Neal, K. K., 370
Ong, S. L., 321
Onken, L. S., 480
Oo, W. N., 292
Oquendo, M. A., 506
Orchard, S., 503
Orchowski, L. M., 4, 186
Orimoto, T., 211
Orlinsky, D., 60
Orlinsky, D. E., 190, 194, 196, 204, 244
Orne, E. C., 125
Orne, M. T., 138
Orne, M., 456
Orsillo, S. M., 318
Ortega-Ruiz, R., 374
Ory, M., 387
Osborn, C. J., 102
Osinska, P., 339, 374
Osler, W., 395
Oslin, D., 224

Öst, L. G., 321, 347
Oswald, L. H., 458
Othmer, E. M., 102
Othmer, S. C., 102
Otto, M., 188
Otto, R., 466
Otto, R. K., 449–450, 453, 463, 469
Ougrin, D., 81, 320
Overbeek, G., 135
Overholser, J. C., 484
Overskeid, G., 261
Overstreet, S., 331
Owen, J., 192, 507
Owens, J. S., 364
Owens, S., 548
Ozenberger, K., 382

Pace, B. T., 507
Pace, T. M., 169
Pachana, N. A., 383
Packard, E., 72
Pallak, M. S., 396
Panagiotaropoulou, G., 443
Paniagua, F. A., 36
Pantin, H., 372
Paolo, A. M., 159
Papp, L. M., 134
Pardo, Y., 508
Parent, M. C., 533

Pargament, K. I., 512
Paris, J., 261–262
Park, C., 347
Park, J., 212
Parke, R. D., 336
Parker, K. C. H., 297
Parkin, S., 212
Parkin, S. R., 213
Parks, B. K., 190, 204
Parks, G. A., 135
Parrott, W. G., 18
Pascal, G. R., 120
Patching, G. R., 407
Patel, S., 428
Patel, S. A., 396
Patel, V., 60, 342
Patnode, C. D., 409
Patt, V. M., 439
Patterson, C. A., 88
Patterson, C. H., 105
Patterson, G. R., 129, 132, 220
Paul, G. L., 14, 76, 135, 218, 234, 242, 368
Pauling, L., 179
Paunesku, 163
Pavlov, Ivan, 48
Payne, L. A., 306, 318
Payne, S. H., 209
Payton, G., 411

Pearce, J. M. S., 423
Pearl, D., 403
Pearson, J., 469
Pechere, J. C., 413
Peckham, A., 188
Peng, W., 409
Pennebacker, J. W., 401
Pepiton, M., 469
Perani, D., 432
Pérez-Rojas, A. E., 110
Pericot-Valverde, I., 339
Perle, J. G., 341
Perls, F. S., 135, 272, 279–281, 284
Perls, L., 279–281, 284
Persons, J. B., 210, 317
Peters, L., 116
Peterson, C., 74, 400
Peterson, D. R., 90
Peterson, J., 81
Peterson, L., 135, 351
Peterson, N., 92, 127
Petkus, A. J., 389
Petriceks, A. H., 378
Petrik, M. L., 511
Petrino, K., 503
Petry, N. M., 331
Pettigrew, T., 239
Phares, V., 354, 373

Philip, D., 488
Piaget, Jean, 351
Piccirillo, M. L., 315
Pickett, T. C., 338
Pickett, T., Jr., 213
Piechowski-Jozwiak, B., 431
Piedimonte, A., 429
Pierce, P. S., 383
Pignotti, M., 217, 348
Pilkonis, P. A., 116
Pillemer, K., 383
Pincus, H. A., 125
Pine, D. S., 265
Pinel, P., 37
Pingitore, D., 192
Pinsof, W. M., 510
Pinto-Coelho, K. G., 212
Piotrowski, Z., 174
Pirelli, G., 452–453
Pirkis, J., 343
Pisani, A. R., 81
Pistorello, J., 317
Pittenger, D. J., 174
Plake, B. S., 144
Plant, E. A., 108
Plante, T. G., 150
Plato, 33
Platt, C. G., 135–136

Plumb-Vilardaga, J., 317
Poland, J., 109
Poldrak, R. A., 427
Pollock, K. M., 415
Polo, A. J., 371–373, 506
Pompili, M., 81
Ponds, R. W., 446
Poock, J. L., 428
Poole, J. C., 400
Pope, K. S., 193, 207, 492–495
Popper, K. R., 58
Portuges, S. H., 259
Post, C. G., 455
Poston, J. M., 77
Pottick, K. J., 125
Powell, R. A., 48
Powers, M .B., 136
Poythress, N., 453, 463
Poznanski, J. J., 58
Presnall, J. R., 173
Preston, C., 428
Price, M., 511
Price, R. H., 399, 402
Prictor, M., 414
Prideaux, D., 5
Prigatano, G. P., 429–430
Princiotta, D., 152
Prinstein, M. J., 374, 488

Prochaska, J. O., 58, 105, 416
Pruett, M. K., 336, 469
Pruitt, L., 242
Przeworski, A., 347
Puente, A. E., 144
Purisch, A. D., 439
Pusch, D., 400
Puska, P., 409
Putnam, E. A., 483
Pythagoras, 33

Qanungo, S., 338
Qato, D. M., 382
Quaglino, A., 422
Qualls, S. H., 379, 387
Quigley, B. M., 287
Qureshi, N. A., 347

Rabasca, L., 57
Rabbitt, S. M., 213, 514
Rabellino, D., 196
Rabin, B. S., 398
Rabiner, D. L., 374
Rachman, A. W., 266
Rachman, S. J., 218
Rafferty, J. E., 360
Ragland, D. R., 406
Raiford, S. E., 158
Raimy, V. C., 23, 218

Raiya, H. A., 512
Rajecki, D. W., 7
Ramachandran, V. S., 511
Ramona, G., 495–496
Ramseyer, F., 212
Rank, Otto, 272–273, 281
Rapaport, D., 174, 265
Rapee, R. M., 113
Rappaport, J., 344–345
Raschle, N. M., 444
Raskin, N. J., 47
Rasmussen, T., 426
Rasting, M., 105
Rathgeber, M., 239
Rathod, S., 505–506
Rathus, J. H., 290, 308
Rathus, S. A., 107
Raue, P. J., 244
Ray, A. R., 364
Ray, R. S., 132
Rayner, R., xxi, 48
Reber, J. S., 58
Redner, R., 133
Reed, D., 406
Reed, G. M., 71, 401
Regier, D. A., 109
Rego, S. A., 221
Rehm, C. D., 382

Reich, W., 116
Reid, A. M., 190
Reid, J. B., 139
Reidy, T. J., 81
Reijnders, M., 236, 374
Reinecke, M. A., 51, 305, 309, 315
Reisman, J. M., 32, 38, 143, 174
Reiss, D., 332
Reitan, R. M., 422, 439, 446
Repuccci, N. D., 468
Rescorla, L., 372
Rescorla, L. A., 357, 371–372
Resnick, P. J., 495
Resnick, R. J., 30
Retzlaff, P. D., 171
Reva, K. K., 161
Reveson, T. A., 410
Reynolds, C. F., 239, 241
Reynolds, C. R., 77, 103
Reynolds, S., 364
Ribeiro, J. D., 81
Ribolsi, M., 443
Rice, M. E., 80, 93
Rice, S. A., 124
Rich, B. A., 464
Richman, L. S., 400
Rickert, V., 413
Ridley, C. R., 93, 95

Rieger, G., 136
Riffin, C., 383
Riggle, E. D. B., 503
Riley, A. W., 240
Riley, W. T., 245
Rimfeld, K., 163
Ring, K., 126
Rios, R., 410
Riper, H., 338
Ripple, C. H., 344
Ritschel, L. A., 235
Roberts, B. W., 85, 229
Roberts, C. F., 459
Roberts, G. E., 5, 177
Roberts, M. C., 352
Roberts, M. H., 432
Roberts, N. J., 413
Robertson, G. J., 161
Robiner, W. N., 500, 512
Robins, L. N., 109
Robinson, J. D., 488
Robinson, R. G., 442
Robinson, S., 382
Robles, G. I., 413
Rock, D. L., 92
Roddy, M. K., 192
Rodebaugh, T. L., 315
Rodolfa, E., 488

Rodrigues, T. F., 344
Rodriguez, A., 366
Rodriguez, E. M., 400
Rodriguez, M. M. D., 505
Roe, A., 479
Roe, D., 212
Roemer, L., 286, 289–290, 292–293, 318
Roesch, R., 458
Roger, D., 406
Rogers, C., xxi, 47–48, 87, 119, 196, 236, 272–277, 279, 283
Rogers, C. R., 181
Rogers, E. B., 344
Rogers, R., 103, 114, 126, 456
Rohde, D., 457
Rohde, P., 344
Rohwedder, S., 387
Roid, G. H., 155–156, 179
Roisman, G. I., 52
Rokeach, M., 165
Rolon-Arroyo, B., 113
Rompa, D., 411
Ronan, G. G., 176
Ronan, K. R., 203
Rønnestad, M. H., 244
Roose, S. P., 197
Rorer, L. G., 92
Rorschach, H., 174, 360
Rosapep, L., 409

Roscoe, E. M., 288
Rosen, D. C., 105–106, 198
Rosen, G. M., 59, 233, 240, 346
Rosen, J., 457
Rosen, R. C., 133
Rosenberg, A., 88
Rosenhan, D. L., 345
Rosenman, R. H., 406
Rosenstock, I. M., 414
Rosenthal, R., 84
Rosenzweig, S., 176
Ross, C. A., 110
Ross, D., 287
Ross, E. L., 242
Ross, M. W., 125
Ross, S., 479
Ross, S. A., 439
Rossi, J. S., 416
Rossini, E. D., 179, 441
Rost, K., 109
Rostosky, S. S., 503
Roth, A., 60
Rothbaum, B. O., 136
Rothke, S. E., 463, 488
Rothman, A. J., 401
Rothman, S., 152
Rottenberg, J., 401
Rotter, J. B., 49, 360

Rourke, B. P., 444
Rousmaniere, T., 76, 192
Roussos, A., 213
Routh, D. K., 30–31, 43, 503
Rovenpor, J. L., 165
Rowe, F. B., 152
Rowe, L. S., 135–136
Roy, A., 407
Rozanski, A., 407
Rozensky, R. H., 10
Ruano-Ravina, A., 413
Rubin, R., 443
Rubinstein, E., 351
Ruby, J., 458
Rudd, M. D., 81
Rudebeck, S. R., 433
Rudy, D., 360
Rugg, M. D., 433
Rugulies, R., 407
Ruini, C., 511
Rummel, C., 288
Ruscio, A. M., 308, 340
Ruscio, J., 458
Rush, B., 37
Russell, D. W., 108
Russell, M. T., 173
Russell, R. L., 135
Rutheford, M. J., 113

Rutherford, B. R., 197
Ruud, T., 262
Ruzek, J. I., 233
Ryan, A., 377
Ryan, J. J., 159
Ryan, K., 239
Ryan, R. M., 190
Rychtarik, R. G., 150

Saab, P. G., 404
Saban-Bezalel, R., 444
Sachs-Ericsson, N., 108
Sackett, D. L., 20
Sackett, P. R., 100, 162, 164, 179
Sacks, O., 432
Sade, R. M., 125
Safer, D. L., 320
Safford, S., 366
Safran, J. D., 199, 244
Sahebzamani, F. M., 407
Sakiris, N., 320
Saklofske, D. H., 103
Sales, B. D., 7, 459, 473
Salisbury, E., 449
Salive, M. E., 377
Salloum, A., 331
Salmon, D. P., 437
Salovey, P., 49, 401
Samaan, Z., 382

Sammons, M., 500
Sammons, M. T., xxii, 242
Samuel, D. B., 236
Sanders, M. R., 369
Sandler, I. N., 240, 344, 511
Santoro, S. O., 539
Santrock, J. W., 346
Santucci, L. C., 513
Saraceno, B., 324
Sarafino, E. P., 402
Sareen, J., 388
Sargent, E. L., 459
Sartorius, N., 70
Sartre, J.-P., 281
Sathyavagiswaran, L., 465
Saunders, S. M., 196, 503
Sawyer, A., 511
Sawyer, A. T., 317, 321
Saxena, S., 71, 324
Sayette, M. A., 7, 268, 482, 520, 522–523, 525, 527, 532–533, 535–537, 539–540, 547
Scanlan, J. M., 385
Schaefer, C. E., 239, 335
Schafer, R., 174
Schatz, D. M., 194–195
Schauenburg, H., 202
Scheckler, S., 388
Scheel, M. J., 190

Scheibe, S., 376
Scheier, M. F., 511
Scherer, K. R., 307
Schiller, E. M., 239
Schirmer, A., 428
Schmalleger, F., 458–459
Schmelkin, L. P., 500
Schmidt, K., 209
Schneck, J. M., 37, 42
Schneider, K. J., 47, 282
Schneider, S., 115
Schneider, S. L., 401
Schneiderman, N., 404
Schnell, R. R., 173
Schnur, J. B., 331
Schoenherr, D., 213
Schofield, M. J., 194
Scholl, M. B., 281
Schönbrodt, F. D., 224
Schrank, F. A., 161, 360
Schröder, T. A., 193
Schroeder, E., 110
Schudlich, D. R. T. D., 134
Schultz, D., 167
Schultz, D. P., 154
Schultz, K. F., 224
Schultz, S. E., 154, 167
Schulz, M. S., 336

Schwab-Stone, M. E., 114, 125, 359
Schwartz, B. K., 449
Schwartz, E. K., 109
Schwartz, R. C., 108
Schwartz, S. J., 506
Schwartzer, G., 241
Schwean, V. L., 103
Scodel, A., 150
Scogin, F. R., 347
Scott, C. L., 495
Scott, K. H., 192
Scott, T., 388
Scoville, W. B., 433
Secades-Villa, R., 339
Sechrest, L., 98
Sedgwick, D., 265
Seegobin, W., 194
Seelau, E., 474
Segal, A. G., 60
Segal, D. L., 103, 113, 115, 387
Segal, Z. V., 317
Segerstrom, S. C., 511
Sehgal, R., 19
Seidler, G. H., 296
Seidman, E., 345
Seligman, D. A., 133
Seligman, M. E. P., 74, 227, 230, 305, 370, 400, 511
Sell, C., 453–454

Sellick, S. M., 512
Selye, Hans, 396
Seroussi, A., 495
Serretti, A., 317
Seto, M. C., 136
Sexton, J. L., xxii
Sgammato, A., 139
Shadish, W. R., 229, 239
Shaffer, A., 512
Shaffer, D., 114, 359
Shaffer, G. W., 35, 488
Shaffer, J. A., 84
Shahar, G., 212
Shakow, D., 478–479
Shambaugh, E. J., 236
Shane, L., 463
Shannon, D., 85
Shapiro, A. K., 204
Shapiro, D., 228
Shapiro, D. A., 227–228
Shapiro, F., 296
Shapiro, J. R., 345
Shapiro, R. W., 115
Sharpe, L., 340
Sharpless, B. A., 5, 487
Shaunessy, E., 164
Shaw, D. A., 132
Shaw, D. L., 125

Shaw, H., 344
Shaw-Ridley, M., 93, 95
Shaywitz, B. A., 444
Shaywitz, S. E., 444
Shea, S. C., 103, 114, 117, 119–120
Shear, M. K., 242
Shechtman, Z., 125
Shedler, J., 268
Sheeran, P., 347
Sheffler, R. M., 192
Sheikh, J. I., 383
Sheitman, B., 132
Shenker, J. I., 432
Shibata, K., 292
Shipley, S. L., 449, 469
Shirk, S. R., 236
Shivy, V. A., 92
Shoham, V., 534
Shochet, I. M., 369
Shoham, V., 22–24, 479–481
Shorr, A., 307
Shrout, P. E., 373
Shuman, D. W., 459, 473
Shure, M. B., 344
Siahpush, M., 375
Siassi, I., 104
Siegle, G. J., 313
Sigelman, C. K., 126

Sijbrandij, M., 239, 241
Silverman, M. M., 81
Silverman, W. H., 26, 213
Silverman, W. K., 234, 364
Simerly, E., 361
Simon, S. S., 441
Simon, T., 35, 154–155
Simons, R. F., 24
Simos, G., 203
Simpson, J. R., 457
Simpson, L. E., 332
Singal, B. M., 407
Singer, B., 229
Singer, J. A., 49, 76
Singer, J. E., 410
Singh, G. K., 375
Singh, J. P., 80
Singh-Franco, D., 413
Singla, D. R., 60, 271, 342–343
Sirhan, S., 458
Sirovich, B. E., 347
Sisti, D. A., 60
Skapinakis, P., 241
Skeem, J., 81
Skidmore, J. R., 225
Skinner, A. T., 374
Skinner, B. F., 48–49
Skodak, M., 479

Skovholt, T. M., 190, 192, 202
Slife, B. D., 58
Sloat, L. M., 459
Slobogin, C., 457, 474
Smit, F., 347
Smith, A. J., 134
Smith, A. P., 398
Smith, C. O., 489
Smith, G. T., 77, 125
Smith, J., 113
Smith, J. Z., 204
Smith, L. A., 462
Smith, M. L., xxii, 228
Smith, S., 474
Smith, S. F., 70
Smith, S. M., 377, 413
Smith, T. B., 505–506
Smith, T. W., 404, 406
Smyer, M. A., 376–377, 387
Snaith, R. P., 133
Snitz, B. E., 91, 93, 467
Snook, B., 467
Snowden, L. R., 109
Snowdon, D. A., 401
Snyder, C. R., 74
Snyder, D. K., 239
Snyderman, M., 152
Sohler, N., 108

Sokoloff, L., 377
Solms, M., 261, 429
Solomon, H. C., 49
Someah, K., 211
Sommer, R., 346, 513
Sommers-Flanagan, J., 103, 106, 190, 278–279, 281–283
Sommers-Flanagan, R., 103, 106, 190, 278–279, 281–283
Song, X., 198
Soni, A., 324
Sonnander, K., 132
Sood, E., 244
Sorensen, J. R., 81
Sorocco, K. H., 108
Sorsdahl, K. R., 125
Soto, A., 506
Soto, C. J., 179
Soulier, M. F., 495
Southam-Gerow, M. A., 366
Sowerby, K., 211
Spangler, D. L., 203
Spearman, C., 152
Speed, B. C., 298
Spence, S. H., 338, 374
Spengler, P. M., 91, 94–95
Sperling, R. A., 437
Sperry, R., 423, 427–428
Sperry, R. W., 205, 207
Spickard, B. A., 4, 186

Spiegler, M. D., 289–290
Spiegler, T. A., 288
Spielberger, C. D., 181
Spielmans, G. I., 512
Spinhoven, P. H., 383
Spiro, A., III, 381
Spirrison. C. L., 383
Spitzer, R. L., 114, 383
Sprafkin, J. N., 68
Spreen, O., 444
Sprenkle, D. H., 510
Spring, B., 409
Spurzheim, J., 34, 420
Squires, L. E., 503
Srivastava, S., 378
St. Lawrence, J. S., 411
Stahl, D., 320
Stam, C. J., 426
Stamm, K., 3, 12, 16, 18
Stams, G. J. J., 240
Standen, P. J., 136
Stanley, M. A., 383
Stanovich, K. E., 164, 179
Stanton, M., 239, 335
Starks, T. J., 411
Starkstein, S. E., 442
Starr, L., 135
Steadman, H. J., 460

Steele, C. M., 163
Steele, S. J., 320
Steen, T. A., 74, 370
Steer, R. A., 77, 171, 181
Steffen, J. J., 198
Stegman, R. S., 211
Steiker, L. K. H., 372, 503
Steiner, A. R. W., 389
Steinert, C., 229
Steinman, S. A., 304, 340
Stekel, W., 265
Steketee, G., 293
Stern, W., 154, 174
Sternberg, R. J., 153
Sternberg, S., 152–153
Sterns, H. L., 388
Stetka, B. S., 109
Steward, W. T., 401
Stewart, C., 512
Stewart, G. L., 150
Stewart, M. O., 241
Stewart, R. E., 228, 245
Stice, E., 79, 344
Stikkelbroek, Y., 374
Stiles, W. B., 209
Stirman, S. W., 190
Stoddard, A. M., 126
Stolorow, R. D., 266, 269

Stone, A. A., 399
Stoney, C. M., 404, 408
Storch, E. A., 372
Stowe, A., 125
Stramler, C. S., 125
Straub, R. O., 402
Strauss, B., 328
Strauss, C., 317
Strauss, E., 426
Strauss, G. D., 125
Stricker, G., 480, 510
Strickland, J. C., 72
Strickler, G., 24, 57
Strohmer, D. C., 92
Strosahl, K. D., 318
Strother, C. R., 479
Strunk, D., 241
Strunk, D. R., 236
Strupp, H. H., 196, 202
Stuart, R. B., 20, 110
Sturmey, P., 234, 510
Su, R., 166
Su, Y.-Y., 387
Sudak, D. M., 321
Sue, D. W., 110, 236, 507
Suh, C. S., 196
Sullivan, H. S., 120, 266, 269–270, 335
Sullivan, J., 452–453

Sullivan, M. F., 202
Suls, J., 406
Summers, R. F., 261
Sundberg, N. D., 67, 98, 165
Suppiger, A., 115
Sussman, S., 347
Sutin, A. R., 387
Suzanne Yew, P. Y., 292
Suzuki, T., 236
Swaminathan, N., 5
Swanson, J. N., 396
Sweet, A. A., 196
Swenson, C. R., 290, 308
Swierc, S. F., 503
Swift, J. K., 190–192, 212
Swim, J. K., 514
Symonds, D., 196–197, 236
Synovitz, L. B., 348
Szanto, K., 377
Szapocznik, J., 372, 506
Szkodny, L. E, 347
Szwedo, D. E., 374

Tabachnick, B. G., 193
Tackett, J. L., 14
Tallent, N., 65, 99
Tan, E. S. N., 512
Tanielian, T., 462
Tao, K. W., 507

Taplin, J. R., 98
Taplin, P. S., 139
Taranta, A., 105
Target, M., 252
Tarnowski, K. J., 150
Tarrier, N., 511
Tatarelli, R., 81
Tatusoka, M. M., 173
Tavris, C., 59, 93
Taub, E., 441
Taylor, A., 261
Taylor, E., 41
Taylor, J. M., 488
Taylor, L., 373
Taylor, P. J., 467
Taylor, S. E., 30, 38, 395–396, 398, 401
Teachman, B. A., 59, 304, 308, 316, 340, 459
Teasdale, A. C., 190
Teasdale, J. D., 305, 317
Tedeschi, J. T., 287
Telch, C. F., 320
Tellegen, A., 169
Temerlin, M. K., 125
Templer, D. I., 482
Terman, L., xxi, 35, 39, 154
Thase, M. E., 298, 321
Thoits, P. A., 402
Thomä, H., 261

Thombs, B. D., 231
Thompson, D., 409
Thompson, L. W., 196
Thompson, P., 470
Thompson-Brenner, H., 232
Thoresen, C. E., 512
Thorndike, E., 48
Thorne, F. C., 93
Thorpe, L., 129, 132
Thurston, I. B., 373
Thurstone, L. L., 153
Thyer, B. A., 217, 348
Tian, X., 125
Tierney, A. L., 254
Tillman, R., 335
Tolin, D. F., 109, 228, 230–232
Tomiyama, A. J., 413
Tompkins, C. A., 428
Tompkins, K. A., 212
Tompkins, M. A., 210
Tompkins, T. L., 500
Torrey, E. F., 459
Tranah, T., 320
Tranel, D., 423
Treadway, M. T., 61, 75
Treanor, M., 290
Treat, S. R., 333–334
Treat, T. A., 24

Triandis, H. C., 110
Trierweiler, S. J., 109
Triller, A., 441
Trimble, J. E., 505
Trost, S. E., 365
Trull, T. J., 72
Tryon, G. S., 105
Tsai, M., 196
Tschacher, W., 212
Tsegahun, I., 125
Tseng, V., 345
Tsuang, M. T., 126
Tuke, W., 37
Tumlin, T. R., 500
Tuomisto, M. T., 407
Turkington, D., 321
Turnbull, O. H., 429
Turner, H., 197, 326
Turner, R. J., 108
Turner, S. M., 108
Turró-Garriga, O., 430
Tutin, J., 92
Twohig, M. P., 318
Tyler, K. L., 420, 424
Tyler, L. E., 98
Tyrrell, D. A., 398

Uchino, B. N., 402
Um, K., 506

Umoren, M. V., 240
Undheim, J. O., 153
Unger, J. B., 506
Ungerleider, L. G., 431
Urban, H. B., 267
Urbina, S., 153, 173

Vahia, I. V., 387
Vaillant, G. E., 400–401
Valenstein, E., 419
Valeri, S. M., 229
van de Vijver, F. R., 169
van den Bercken, J., 92
Van den Hout, M. A., 297
Van Der Heijden, P. T., 168
van der Laan, P. H., 240
van der Maas, H. L. J., 152–153
van der Stouwe, T., 240
Van Dijk, S., 320–321
van Loon, A., 505
van Manen, J. G., 190
van Schie, K., 297
van Straaten, E. C., 426
van Straten, A., 242
van Veen, S. C., 297
Van Voorhis, P., 449
Van Zeijl, J., 369
VandeCreek, L., 492–493, 495
Vandenberghe, R., 437

Vandenbos, G. R., 261
Vanderschaeghe, G., 437
Vane, J. R., 176
vanSchaik, A., 505
Vansteenkiste, M., 190
Varley, R., 347
Varvarigou, V., 404
Vasquez, M. J. T., 207, 492–495
Velez, C. E., 468
Velicer, W. F., 416
Velten, E., 376
Venturyera, V, 201
Verdell, H., 522
Verfaellie, M., 433
Vermeij, A., 52
Vernon, C. E., 165
Vertilo, V., 511
Vervliet, B., 290
Villatoro, A. P., 505
Villatte, J. L., 317
Vincent, G. M., 79
Vîslă, A., 204
Vitacco, M. J., 469
Vitiello, B., 388
Vogel, D. L., 4, 186
Vogel, M. E., 373
von Ranson, K. M., 244
von Stumm, S., 132

Vonk, I. J., 321
Vos, T., 343
Vrieze, S. I., 94
Vyse, S. A., 179

Wachtel, P. L., 262
Wada, J., 426–427
Wadden, T. A., 135
Wade, A. G., 195
Wade, C. J., 321
Wade, S., 339, 374
Wadley, V., 150
Wagner, F. E., 296
Wagner, J. P., 428
Wahl, H.-W., 381
Walfish, S., 499
Walker, B. B., 245
Walker, C. M., 413
Walker, E. F., 134
Walker, L., 17, 450
Walkup, J. T., 367
Wallace, E., 377
Wallace, L. M., 244
Wallace, T., 360
Wallen, R. W., 112
Waller, G., 326
Waller, N. G., 173
Wallerstein, R. S., 266
Walsh, B. W., 156

Walsh, L. M., 192
Walter, A., 118
Walter, S. D., 382
Walter, T., 240
Walters, E. E., 188
Waltman, S. H., 512
Wamboldt, M., 332
Wampold, B. E., 21, 76, 192, 198, 231, 235–237, 244
Wang, P. S., 514
Wang, Z., 241, 364
Wapner, W., 428
Ward, C. H., 113–114
Ward, M. P., 148, 171
Warmerdam, L., 242
Wasserman, D., 240
Wasyliw, O. E., 114
Watkins, C. E. Jr., 110
Watkins, M. W., 58, 159, 179
Watson, D., 83, 125
Watson, J. B., xxi, 48
Watson, R. I., 38, 40, 274, 279, 282–283
Watts, A. L., 70
Watts, P., 92
Weakland, J. H., 335
Weaver, C., 321
Weaver, W., 85
Webb, A., 366
Webb, C., 484

Webb, T. L., 347
Weber, E., 31, 39
Wechsler, D., 156–159, 161, 179, 181, 385
Wedding, D., 500
Weed, N. C., 148
Weeks, G. R., 333–334
Weeks, W. B., 347
Weick, K. E., 128
Weil, T. M., 129
Weinberger, L. E., 465
Weiner, B., 305
Weiner, I. B., 174
Weinstein, E. A., 429
Weinstock, J., 331
Weinstock, R., 495
Weir, K., 144
Weisberg, R. B., 109
Weiss, B., 227
Weiss, R. D., 125
Weissman, H. N., 468
Weissman, M. M., 269, 522
Weisz, J. R., 59, 227–229, 244, 336, 364
Welge, J., 188
Wellmer, J., 427
Wells, K. C., 240
Welsh. B. C., 344
Wenzel, A., 330
Werboff, S. F., 474

Wergeland, G. J. H., 331
Werner, C., 511
Werntz, A., 548
Werntz, A. J., 308
Werry, A. E., 419
Wersebe, H., 239
Wesbecher, K., 376
Wessinger, C. M., 433
West, A. N., 347
West, M., 126
West, S. L., 370
Westen, D., 74, 84, 223, 232, 261
Westra, H. A., 197
Wetherell, J. L., 388
Wetzler, R. G., 388
Wexelbaum, S. F., 488
Whaley, A. L., 108
Wheeler, S., 209
Whipple, J. L., 182
Whisman, M. A., 239
Whitaker, H., 34
Whitaker, R., 22
White, D., 460
Whiteford, H., 514
Whitehead, M. L., 74
Whitehouse, W. G., 125
Whitton, S., 188
Wicherski, M., 480, 482, 522

Widiger, T., 73
Widiger, T. A., 72, 125
Wiesner, W. H., 126
Wiggins, J. G., 500
Wilberg, T., 106
Wildman, R. W., 179
Wilk, S. L., 100
Wilkinson, G. S., 161
Wilkinson, J., 377
Wilkosz, P. A., 435
Williams, C. L., 409
Williams, C. R., 503
Williams, J. M. G., 317
Williams, J. W. B., 114, 383
Williams, K. D., 450
Williams, O. B., 211
Williams, P., 75
Williams, P. G., 404
Williams, R. B., 114, 406
Williams, T. R., 132
Williamson, J., 414
Williamson, J. B., 533
Willock, B., 261
Wills, T. A., 402
Willutzki, U., 244
Willyard, C., 514
Wilson, C., 364
Wilson, G. T., 26, 241, 347

Wilson, K. G., 318
Wilson, S., 133
Wilson, T. D., 261
Winerman, L., 511
Wing, J., 114
Wing, S., 405
Winnicott, D., 265
Winocur, G., 446
Winters, K. C., 133
Wiser, S., 244
Witmer, L., xxi, 31–33, 39, 41
Witt, A. A., 317
Wittchen, H. U., 114
Wittmann, J. P., 469
Wodak, A., 125
Wolańczyk, T., 13
Wolfle, D., 43
Wolfson, D., 439
Wolfson. W., 150
Wolitzky, D. L., 255, 258, 261, 266
Wolk, D. A., 433
Wolpe, J., 291
Wong, H. M., 110
Wong, J. M., 407–408
Wong, S. C. P., 81
Wood, A., 74
Wood, A. M., 174, 511
Wood, J. M., 176, 179, 360

Woodhead, E. L., 392
Woods, S. W., 242
Woodworth, R., 41, 168
Woody, S., 316
Wortman, C. B., 399, 402
Woud, M. L., 224
Wright, A. J., 98
Wright, C. V., 144
Wright, J. H., 321
Wright, M. O., 400
Wrightsman, L. S., 450, 452
Wroble-Biglan, M. C., 396
Wulfert, E., 72
Wulsin, L. R., 407
Wundt, W., xxi, 31, 35, 39, 42
Wymbs, B. T., 364
Wynder, E. L., 409

Xu, J., 375
Xu, X., 511

Yadin, E., 293
Yagoda. G., 150
Yalom, I. D., 328, 330
Yang, M., 81
Yarhouse, M. A., 512
Yarrow, M., 377
Yasui, M., 371
Yates, A., 457–458

Yeasavage, J. A., 383
Yeh, C. J., 346
Yerkes, R., 41
Yip, T., 506
Yon, Y., 383
Yoshikawa, H., 344, 370, 511
Yoshimasu, K., 408
Young, E. S., 398
Young, L. D., 410
Youngstrom, E. A., 77, 92, 144, 234
Yourtee, E., 414
Yuan, S., 203
Yuille, J. C., 474

Zald, D. H., 91, 93, 467
Zamboanga, B. L., 506
Zandberg, L. J., 347
Zane, N., 190
Zapf, P., 452–453, 458
Zárate, M. T., 506
Zaslow, M., 140
Zautra, A. J., 410
Zaza, C., 512
Zbozinek, T., 290
Zebb, B. J., 383
Zee, K. S., 402
Zeiss, A. M., 233, 379
Zelgowski, B. R., 469
Zemansky, M. F., 488

Zetin, M., 126
Zieve, G. G., 321
Zigler, E., 344
Zigmond, A. S., 133
Zilboorg, G., 37
Zilcha-Mano, S., 197, 283
Zimmerman, B. E., 212
Zimmerman, M. A., 344
Zinbarg, R. E., 292
Ziskin, J., 93
Ziv-Beiman, S., 212
Zoellner, L., 190
Zoellner, L. A., 242
Zola-Morgan, S., 421
Zuckerman, E. L., 346
Zuk, J., 444
Zweig, R., 378
Zych, I., 374
Zytowski, D. G., 165

Subject Index

16 Personality Factors Questionnaire (16PF5e), 173

abulia, 435
Academy of Behavioral Medicine Research, 395
Academy of Psychological Clinical Science (APCS), xxii, 7, 481
acceptance and commitment therapy (ACT), 316, 318
acceptance-based therapy, 314–322
  clinical applications, 316–317
  current status of, 321
  integrating with cognitive-behavior therapy (CBT), 317–321
  theoretical foundations and extensions, 315–316
access to care
  children and adolescents, 372–373
Achenbach System of Empirically Based Assessment (ASEBA), 357
achievement tests, 160–161
  children, 359–360
Ackerman–Schoendorf Scales for Parent Evaluation of Custody (ASPECT), 469
acquiescent response style, 150
active listening, 119, 276
activity scheduling, 298–299
  children and adolescents, 11–16

actuarial prediction. See statistical prediction
Adderall, 366
administrative activities of clinical psychologists, 15–16
adolescents. *See* clinical child psychology
Adult Functional Adaptive Behavior Scale, 383
advance medical directives, 464
ageism, 387
Agnew relationship measure (ARM), 196
agnosia, 422
Ake v. Oklahoma, 456
akinetic mutism, 435
algorithms, 113
all-or-none thinking, 50
alternative treatments/medicine, 10, 347–348
Alzheimer's disease, 52, 436–437
American Academy of Matrimonial Lawyers, 468
American Association for Applied Psychology (AAAP), xxi, 43
American Association for Marriage and Family Therapy, 518
American Association of Clinical Psychologists (AACP), 43
American Association of Clinical Psychology (AACP), xxi
American Association of Geriatric Psychiatry, 377
American Board of Examiners in Professional Psychology, xxi, 44
American Board of Geropsychology (ABGERO), 380
American Board of Professional Psychology (ABPP), 380, 483, 488
    certification, 489
American Educational Research Association, 181
American Geriatrics Society, 377
American Heart Association

Life’s Simple 7, 404–405
American Journal of Community Psychology, 345
American Psychiatric Association
DSM-I publication, xxi
DSM-II publication, xxii
DSM-III publication, xxii
DSM-IV publication, xxii
American Psychiatric Nurses Association, 518
American Psychological Association (APA)
accredited graduate programs, 534
Division of Clinical Neuropsychology, 446
Division of Clinical Psychology, 3
divisions (interest groups), 3
early directions and developments, 43–44
Ethical Principles of Psychologists and Code of Conduct, xxii, 6, 181, 206–207
ethical standards, 100, 490–491
ethical standards for particular situations, 493–494
Ethical Standards for Psychologists, xxii
founding of, xxi, 43
Guidelines and Principles for Accreditation of Programs in Professional Psychology, 479
Guidelines for Child Custody Evaluations in Family Law Proceedings, 469–470
Guidelines for Psychological Evaluations in Child Protection Matters, 471
Guidelines for Test User Qualifications, 181
internships, 7
Model Act for State Licensure of Psychologists, 488

Multicultural Guidelines, 503–505
PsycTESTS database, 144
Record Keeping Guidelines, 210
Standards for Educational and Psychological Tests, 181
Standards for Providers of Psychological Services, xxii
Standards of Accreditation for Health Service Psychology, 479
Stress in America survey, 397–398
Task Force on Promotion and Dissemination of Psychological Procedures, 230–233
American Psychological Association of Graduate Students (APAGS), 549
American Psychological Society, xxii
American Psychologist, 478–480
American Psychology-Law Society, 448
American Psychosomatic Society, 395
Americans with Disabilities Act, 100
amnesia, 422
amphetamine, 366
analog behavior observation (ABO), 134
analytical psychology (Jung), 265
anchoring bias, 92
Annals of Behavioral Medicine, 395
anorexia nervosa, 240
anosognosia, 428–430
anthropology, 132
anxiety and related disorders
psychosocial treatments for children, 364–366
Anxiety and Related Disorders Interview Schedule for DSM-5 (ADIS-5), 383
aphasia, 422

apraxia, 422
aprosodia, 428
aptitude tests, 160–161
Army Alpha intelligence test, 41
Army Beta intelligence test, 41
aromatherapy, 10
assertiveness training, 297–298
assessment. *See* clinical assessment
Association for Psychological Science (APS), 481
Association of Consulting Psychologists (ACP), 43
Association of Psychology Postdoctoral and Internships Centers (APPIC), 484
Association of State and Provincial Psychology Boards (ASPPB), 486, 488–489
astronomy
individual differences between observers, 33–34
attachment theory, 270
attention bias modification, 339
attention-control research design, 222
attention deficit/hyperactivity disorder (ADHD), 444
medications, 366
psychosocial treatments, 364–366
attitudes
psychological tests, 165–167
autism spectrum disorder (ASD), 72, 511
psychosocial treatments, 364–366
automatic thoughts, 304–306
availability heuristic, 91–92

aversion therapy, 299

bandwidth-fidelity (breadth-depth) dilemma in assessment, 85
Beck Depression Inventory (BDI-II), 171
Behavior and Symptom Identification Scale (BASIS-32), 182
behavior rating scales
  assessment of children, 357–359
behavior therapy, 49, 286–302
  ABC analysis of behavior, 289
  activity scheduling, 298–299
  assertiveness training, 298
  assessment, 288–289
  aversion therapy, 299
  behavioral activation, 298–299
  biofeedback, 301
  case example (exposure hierarchy), 293–295
  case example (response prevention), 293–296
  case example (Robert Jackson), 299–300
  classical conditioning, 287
  clinical applications, 290–318
  contingency management, 301
  definition, 286–287
  expectancy violation, 290
  exposure techniques, 290–297
  flooding technique, 292
  functional analysis of behavior, 288–289
  goals of, 290
  habit reversal, 301
  habituation, 290

interoceptive exposures, 292
observational learning, 287
operant conditioning, 287
progressive relaxation training (PRT), 291–292
punishment, 299
reciprocal inhibition principle, 291
response costs, 301
role of the therapist, 289–290
social skills training, 297–298
stimulus, organism, response, consequences (SORC) approach, 288–289
systematic desensitization, 290–291
theoretical foundations, 287–288
token economies, 302
vicarious conditioning, 287
behavioral activation, 298–299
behavioral approach, 48–49
behavioral avoidance tests, 136–137
behavioral couples therapy (BCT), 239
behavioral family therapy, 239
behavioral medicine, 395–396
See also health psychology, 396
behavioral parent training, 239, 335–336
behaviorally-based family therapy, 239
Bender-Gestalt Test, 41
Bender Visual Motor Gestalt Test, 177–179
Benton’s Visual Retention Test, 434
between-subjects research designs, 220–224
bias

anchoring bias, 92
avoiding in clinical assessment, 64
confirmation bias, 92, 130, 310
effects of clinicians' personal biases on assessments, 124–125
interpretation bias, 339
question of racial bias in psychological diagnosis, 107–109
response bias, 150
situational bias in observational assessment, 138–139
social desirability bias, 150
bibliotherapy, 203, 240, 346–347
Binet scales, 154–156
Binet-Simon Intelligence Scale
1908 revision, xxi
first publication, xxi
Binet-Simon scale, 35, 154
biofeedback, 347
biological approach, 52–53
biopsychosocial approach to psychopathology, 52
biopsychosocial model, 395
bipolar disorder, 37, 240
blindness, 431
blindsight, 431
Blue Cross, 499
Blue Shield, 499
bona fide interventions, 23–24
Boulder Conference (Colorado, 1949), 479
Boulder model of training, 23–24, 44, 479
box score reviews, 227–228

branching rules, 113
Bricklin Perceptual Scales, 469
Brief Fear of Negative Evaluation scale, 306
Broca's area of the brain, 421–422
Buros Center for Testing, 144

California Psychological Inventory (CPI), 173, 178
California Psychotherapy Alliance Scales, 196
California School of Professional Psychology (CSPP), xxii, 482
California Verbal Learning Test, 434
Campbell Interest and Skill Survey (CISS), 165
Canadian Psychological Association, 234
cancer patients
  health psychology interventions, 410
cardiovascular disease
  hostility risk factor, 406–408
  Life's Simple 7 (AHA), 404–405
  preventive interventions, 409
  psychological risk factors, 406–408
  risk factors for, 404–408
  role of stressors, 404–406
case examples
  behavior therapy (Robert Jackson), 299–300
  behavioral problems in children (Jamal Jackson), 368–369
  child assessment (Rachel Jackson), 362–363
  clinical assessment of older adults (Danutė Bagdonas), 385–386
  clinical geropsychology (Danutė Bagdonas), 374–375
  comparing clinical approaches (Rachel Jackson), 53–55
  cultural competence (Alejandro Alvarez), 507–508

cultural competence (Eric Yang), 216–217
evidence-based practice (Eric Yang), 216–217
exposure hierarchy (Lena Jackson), 293–295
family therapy (Sal), 335–336
health psychology (Regina Bagdonas), 415–417
indications for clinical assessment (Rachel Jackson), 63–64
insanity defense (Adomas Bagdonas), 455
Jackson family situation, 1–2
neuropsychology (Ellen Yang), 418–419
person-centered therapy (James Jackson), 277–279
psychoanalysis (Lena Jackson), 255–261
response prevention, 293–296
systematic treatment selection, 204–212
treatment of older adults (Danutė Bagdonas), 389–390
case formulation (case study guide), 210–212
case-study model, 332–334
catastrophizing, 50
cathartic method, 252–253
Certificate of Professional Qualification in Psychology, 488
certification in psychology, 486–489
certification of clinical psychologists, 5–6
child custody
evaluations, 467–470
mediation, 469–471
termination of parental rights, 471
Child Depression Inventory-2, 357
Child Psychiatry and Human Development, 352
child psychology. *See* clinical child psychology

Children's Apperception Test (CAT), 177, 360
CIA (formerly Office of Strategic Services, OSS), 134
civil competency, 463–464
Civil Rights Act (1964), 100
Civil Rights Act (1991), 100
classical conditioning, 48, 287
classification of mental health disorders, 70–75
client-centered therapy. *See* person-centered therapy
client interventions
  influence of therapist characteristics, 190–195
client satisfaction surveys, 227
clients
  access to new information about their problems, 203
  autonomy of, 190
  characteristics of, 188–190
  coping style, 190
  diversity of, 18–19
  extra-therapy tasks (homework), 203
  influence of characteristics on treatment outcomes, 188–190
  motivation to change, 190
  positive expectations of therapy, 203–204
  preferred treatment, 190
  premature termination of therapy, 212–213
  prevalence of different disorders, 188
  termination of therapy, 212–213
  treatment utilization issues, 188
clinical assessment
  assessment report

assessment outline, 95–97
clarity of the report, 97–98
incremental validity, 98–99
relevance to goals, 98
usefulness of reports, 98–99
avoiding bias, 64
children, 356–363
achievement tests, 359–360
behavior rating scales, 357–359
behavioral observation, 360–361
case example (Rachel Jackson), 362–363
clinical interviews, 359
inconsistent assessment information, 361–362
intelligence tests, 359–360
projective tests, 360
special considerations in child assessment, 356–357
clinical intuition, 90–94
clinical judgment and decision-making, 90–95
communicating assessment results, 95–99
core competencies in assessment, 88
definition, 64
definition of assessment, 12–13
discrete categories versus dimensional diagnosis, 72
ethical considerations, 99–100
goals, 69–82
classification, 70–75
dangerous behavior prediction, 79–81
descriptive assessment, 75–76

diagnosis, 70–75
dimensional approaches to diagnosis, 73–74
forensic evaluations, 79–81
ongoing outcome assessment, 76–77
predicting performance, 79
prediction, 77–81
prognosis, 77–79
treatment planning and evaluation, 76–77
indications for (Rachel Jackson example), 63–64
instruments
assessment context and instrument choice, 87
bandwidth-fidelity (breadth-depth) dilemma, 85
choice of, 82–90
clinician experience and choice of, 86–87
core competencies in assessment, 88
influence of cultural context, 87–88
reliability, 83
standardization, 85
theoretical approach and choice of, 86–87
validity, 83–85
older adults, 382–386
assessment methods, 382–385
case example (Danutė Bagdonas), 385–386
clinical interviews, 383
medical records, 385
neuropsychological assessment, 383–385
self-report measures, 383–384
process, 64–69

assessment report, 69
collecting assessment data, 68
communicating assessment results, 69
data processing, 68–69
forming conclusions, 68–69
inferences from the data, 68–69
informed consent, 68
planning data collection procedures, 65–68
presenting problem, 65
referral question, 65–66
referral source, 65
value of multiple assessment sources, 68
types of errors, 64
clinical attitude, 4
Clinical Child and Family Psychology, 352
clinical child psychology
access to care, 372–373
activity scheduling, 365
attention to the contexts of behavior, 354–355
building resilience, 370
case example (treatment of childhood disorders), 368–369
changes in the DSM, 351–352
clinical assessment of children, 356–363
confidentiality, 355
definition, 350–351
developmental psychopathology, 352
deviancy training related to psychosocial treatment, 357–368
diversity, 371–372

focus on developmental stages, 353–354
future of, 371–374
history of, 351–353
interdisciplinary approaches to research and practice, 373
internet and youth mental health, 373–374
multiculturalism, 371–372
pharmacological interventions, 366–368
prevention of childhood disorders, 369–371
processes for seeking help, 355
psychosocial treatments, 364–366
technology and youth mental health, 373–374
treatment and prevention of disorders, 364–369
unique characteristics, 353–356
clinical geropsychology
adapting to challenges in later life, 375–376
ageism, 387
aging populations, 375
anxiety, 387
bio-psycho-socio-spiritual approach, 380–381
clinical assessment of older adults, 382–386
depression, 387
diversity, 391
ethical considerations, 388
focus on lifespan development, 380–381
future developments, 391–392
growth of geropsychology, 377–378
history of, 375–378
life expectancy disparities, 375

mental health in old age, 376–377
multiculturalism, 391
need for more geropsychologists, 378, 392
pharmacological treatments, 389
Pikes Peak Model, 379
psychosocial treatments, 388–389
role of advancing technology, 391–392
role of the geropsychologist, 374–375
sleep disorders, 387
special considerations in treating older adults, 387–388
study of aging, 377–378
successful aging, 376–377
training in, 379–380
treatment case example (Danutė Bagdonas), 389–390
treatment of older adults, 387–390
treatment settings, 388
unique characteristics, 379–381
work settings, 380
clinical interventions
activities of clinical psychologists, 13
assigning extra-therapy tasks (homework), 203
case formulation (case study guide), 210–212
challenges to therapists' values, 207–208
client characteristics, 188–190
client factors in treatment outcomes, 188–190
clinical utility focus, 213
defintion of psychotherapy, 186
developing faith, hope, and expectations for change, 203–204

e-health interventions, 28
ethical guidelines, 205–209
fees, 209–210
fostering insight, 202–203
goals of, 201–205
inpatient settings, 200
mental health service delivery methods, 213–214
outpatient settings, 199–200
overview, 185–187
practical aspects, 209–214
premature termination of therapy, 213
prevalence of different disorders, 188
providing new information (education), 203
psychotherapy for psychotherapists, 194–195
public (mis)perception of psychotherapy, 186
range of approaches to psychotherapy, 186–187
record keeping, 210
reducing emotional discomfort, 202–214
settings for psychotherapy, 199–201
termination of therapy, 212–213
therapeutic alliance, 195–199
therapist objectivity, 212
therapist self-disclosure, 212
treatment delivery models, 27–28
treatment duration, 209–210
treatment planning, 210–211
treatment utilization issues, 188
trends in, 213–214

See also psychotherapy.
clinical intuition, 90–94
anchoring bias, 92
availability heuristic and, 91–92
clinical prediction versus statistical prediction, 92–94
confirmation bias and, 92
illusory correlations, 92
clinical judgment and decision-making, 90–95
clinical intuition, 90–94
improving clinical judgment, 94–95
clinical psychologists
activities, 11–16
administration, 15–16
assessment, 12–13
clinical research, 13–15
consulting, 15
teaching, 15
treatment, 13
certification, 5–6
clinical attitude, 4
competence testing, 7
demographic diversity, 17–18
diversity of clients, 18–19
doctoral degrees, 7
educational requirements, 6
ethical standards, 6
legal requirements, 5–6
licensing, 5–6

personal characteristics, 5
prescription privileges, 27
requirements for, 4–7
scientific attitude, 5
scientific thinking, 5
sub-doctoral qualifications and job titles, 7
supervised clinical experience, 7
typical earnings, 17
work settings, 16–17
clinical psychology
alternatives to the face-to-face treatment model, 60–61
burden of mental illness, 59–60
changing landscape of clinical practice, 60–61
clinical tradition, 35–39
current debates
eclecticism and integration, 24–25
science and practice, 20–24
definition, 2–3
effects of deinstitutionalization on people with mental disorders, 60
empirical tradition, 31–33
future trends, 59–61, 509–515
dissemination of knowledge about psychology, 513–514
interdisciplinary science and practice, 510–511
mental health literacy, 513–514
national and international outreach, 514
positive psychology, 511
psychotherapy integration, 510
role of spirituality, 511–512

role of technology, 512–513
telepsychology, 512–513
training, 510
growth of, 40–45
clinicians become psychotherapists, 41–42
clinicians form professional organizations, 43–44
expansion of psychological testing, 40–41
health care environment, 25–28
measurement of individual differences, 33–35
mechanisms of change in psychotherapy, 59
mental hospitals vs. prisons and jails, 60
multicultural competence, 502–509
new approaches to diagnosing psychological disorders, 61
popularity of the discipline, 3–4
portrayal in popular media, 3–4
professional independence, 497–502
professional regulation, 486–490
professional training, 478–485
psychometric tradition, 33–35
recent changes in the field, 477
related mental health professions, 3–8
roots of, 30–40
science-practice gap, 59–60
significant dates and events, xxi–xxiii
theoretical approaches, 45–59
behavioral approach, 48–49
biological approach, 52–53
cognitive approach, 49–50

cognitive-behavioral approach, 51
comparing approaches (Rachel Jackson), 53–55
eclectic approach, 58–59
humanistic approach, 47–48
influence of Carl Rogers, 47–48
influence of Sigmund Freud, 45–47
integrative approach, 58–59
psychodynamic approach, 45–47
social systems approaches, 51–52
transdiagnostic approaches, 59
Clinical Psychology Review, 234
Clinical Psychology: Science and Practice, 234
clinical science model, 24
clinical scientist model, 483–484
clinical significance of results, 219–220
clinical tradition, 35–39
clinical utility focus, 213
Clinician Home-based Interview to Assess Function (CHIF), 113
cognitive-affective-relational-behavior therapy, 510
cognitive approach, 49–50
cognitive-behavior therapy (CBT), 51, 314–322
clinical applications, 316–317
current status of, 321
delivered by mental health professionals via the internet (iCBT), 338
integrating with acceptance-based therapy, 317–321
theoretical foundations and extensions, 315–316
unified protocol, 318–320
cognitive-behavioral approach, 51

cognitive-behavioral group therapy (CBGT), 238–239, 329–330
cognitive bias modification (CBM), 308, 339–341
cognitive distortions, 50
cognitive therapy, 302–314
  assessment, 306
  automatic thoughts, 303–306
  cognitive distortions (biases), 304–305
  cognitive mediation, 303
  cognitive restructuring, 307
  cognitive specificity hypothesis, 305–306
  cognitive styles, 303
  cognitive triad, 308
  collaborative empiricism, 306
  continuum technique, 311–313
  core beliefs, 303
  definition, 302
  goals of, 307
  guided thoughts, 310–311
  negative attributional style, 305–306
  psychoeducation, 309
  rational-emotive behavior therapy, 308–309
  re-evaluating and replacing maladaptive thoughts, 309–310
  role of the therapist, 306–307
  schemas, 303–304
  Socratic questioning, 310–311
  theoretical foundations, 302–307
  thought records, 311–312
  treatment methods, 307–313

work of Aaron Beck, 50, 307–308
collaborative empiricism, 306
collective unconscious (Jung), 265
communicating assessment results, 95–99
community-based participatory research (CBPR), 345
Community Mental Health Centers Act (1962), 345
Community Mental Health Clinics, 42
Community Mental Health Journal, 345
community psychology, 345
ecological perspective, 345
competence testing for clinical psychologists, 7
competency
ethical issues, 207
complementary treatments, 3–10, 347–348
Composite International Diagnostic Interview (CIDI-2), 114
Concerta, 366
concurrent validity of assessment methods, 84
conditioning
behavioral approach to treatment, 48–49
conditions of worth (Rogers), 47–48, 273
conduct disorder (CD)
psychosocial treatments, 364–366
confidentiality, 206–207
clinical child psychology, 355
confirmation bias, 34, 92, 130, 310
conflict of interest, 207
congruence, 277
Consolidated Standards of Reporting Trials (CONSORT standards), 224–225

construct validity of assesment methods, 83–84
constructivism, 266
consulting activities of clinical psychologists, 15
content validity of assessment methods, 84
continuing education (CE), 488
continuum technique, 311–313
contrived observations., 134
controlled observation, 131, 134–137
convergent validity, 126
conversion disorder, 38
coping
  definition, 399
  strategies for, 399–400
core competencies in assessment, 88
correctional psychology, 283
Council for the Advancement of Psychological Professions and Sciences, xxii
Council of University Directors of Clinical Psychology, 517, 532
Counseling and Psychotherapy (Rogers), xxi
counseling psychology, 8
countertransference, 254
couples therapy, 239, 331–332
  comparison with family therapy, 337
  conjoint therapy, 333
  diagnosis, 332
  integrative behavioral couples therapy, 334
  mental health service delivery, 331–337
  methods, 332–334
  separation counseling, 333

social context, 336
Crawford Small Parts Dexterity Test, 161
criminal competence, 450–454
criminal profiling, 466–467
Crisis Intervention Semistructured Interview, 113
crisis interviews, 106
criterion validity of assessment methods, 84
Critical Incident Stress Debriefing, 233
Cruzan v. Director, Missouri Department of Health, 464
cultural competence, 109–110
case study (Eric Yang), 216–217
See also multicultural competence, 508
cultural context
influence on choice of assessment instruments, 87–88
cultural issues
applicability of psychological tests, 180–181
clinical interviews, 107–110
cultural sensitivity, 109–110
culturally-adapted treatment, 505
culture-bound syndromes, 109

dangerous behavior
ability of clinicians to predict, 79–81
debriefing interviews, 106
decision trees, 113
defense mechanisms, 250–252
deinstitutionalization of mental health care
effects on patients, 60
Delaware Conference (2011), 480

Delaware Project, 480
dementia, 436–437
demographic diversity of clinical psychologists, 17–18
demographic factors
  influence on health, 405–406
dependent variable, 220
depression
  diagnostic issues, 72
  negative attributional style, 305–306
  neuropsychological approach, 442–443
  psychosocial treatments for children, 364–366
Development and Psychopathology, 352
developmental aspects of stress, 398
developmental disorders
  neuropsychological approach, 444–445
developmental psychopathology, 352
deviancy training, 357–368
Dexedrine, 366
diagnosis of mental disorders
  alternatives to DSM and ICD, 61
  classification systems, 70–75
  dimensional approaches, 73–74
  Hierarchical Taxonomy of Psychopathology (HiTOP), 61, 74
  history of the DSM, 70–73
  positive psychology approach, 74
  Psychodynamic Diagnostic Manual (PDM), 74
  purpose of, 70
  question of racial bias, 107–109

Research Domain Criteria (RDoC), 61, 74–75
Diagnostic and Statistical Manual of Mental Disorders (DSM)
changes to cover child psychology, 351–352
history of, 70–73
Diagnostic and Statistical Manual of Mental Disorders (DSM-5), 37, 61, 171
concerns about narrowness of information considered, 72
concerns about the number of diagnostic categories, 72–73
conditions which are excluded, 72
discrete categories versus dimensional diagnosis, 72
evaluation of this edition, 72–73
features of, 70–71
significant changes in this edition, 70–71
Diagnostic Interview Schedule (DIS), 114
Diagnostic Interview Schedule for Children (DISC), 113, 359
Diagnostic Interview Schedule for Children, Revised (DISC-R), 114
diagnostic labeling, 70
dialectical behavior therapy (DBT), 320–321
diathesis-stress model, 52–53
differential diagnosis, 70
direct conditioning, 48
Direct Observation Form (DOF), 133
direct questions, 112
Disabilities Education Act, 100
discriminant validity, 84, 126
dissemination and implementation of clinical interventions, 325–327
challenges of, 325–326
clinical care delivery models, 325
new models of service delivery, 326–327

dissemination and implementation science, 324–325
dissemination of knowledge about mental health, 513–514
diversity
  applicability of psychological tests, 180–181
  client diversity, 18–19
  clinical child psychology, 371–372
  clinical geropsychology, 391
  demographic diversity of clinical psychologists, 17–18
Doctor of Psychology (Psy.D.) degree, 482–483
doctor–patient interview schema, 120
doctoral degrees held by clinical psychologists, 7
Draw-a-Person (DAP) test, 177
Drug Abuse Resistance Education (DARE) program, 370
Dusky v. United States, 451
duty to warn, 494–495
dyslexia
  neuropsychological approach, 444

earnings of clinical psychologists, 17
Eating Disorder Examination Interview, 126
echolalia, 435
echopraxia, 435
eclectic approach, 58–59
eclecticism, 24–25
ecological perspective, 345
ecological validity, 129
ectopias (misplaced cells) in the brain, 444
educational requirements for clinical psychologists, 6
effect size statistic, 228

effectiveness of psychotherapy treatments, 219
efficacy of psychotherapy treatments, 219
ego (Freud), 46
ego psychology, 265
eHealth interventions, 28
eHealth models, 338–341
elderly people. *See* clinical geropsychology
emotion-focused coping, 399–400
emotion-focused therapy, 282–283
emotional expression, 401
emotionally-focused couple therapy (EFCT), 239
empathy, 275–277
empirical tradition, 31–33
empirically-supported treatments (ESTs), 230–233
empty chair technique, 280
end-of-life decisions, 464
Equal Employment Opportunity Act, 100
Equal Employment Opportunity Commission (EEOC), 181
equipotentiality in the brain, 420–421
ethical issues, 496
  APA ethics code, 206–207
  APA guidelines and standards, 100
  challenges to therapists' values, 207–208
  clinical assessment, 99–100
  clinical interviews, 107–110
  competency, 207
  confidentiality, 206–207
  conflict of interest, 207

ethical dilemmas that therapists may face, 206
guidance for specific areas of practice, 207
guidelines for clinical interventions, 205–209
informed consent, 207
standards for clinical psychologists, 6
use of psychological tests, 181
working with older adults, 388
See also professional ethics.
Ethical Standards for Psychologists (APA), xxii
ethics boards, 6
ethnic minorities
underutilzation of mental health care, 107
ethnography, 387
evidence
scientific thinking, 21
evidence-based practice, 20–23, 217–218, 233–235
case example (Eric Yang), 216–217
Examination for Professional Practice in Psychology (EPPP), 7, 486–487
existential therapy, 281–282
exorcism, 36
expectancy violation, 290
experiential therapies, 47
experimental designs, 219–224
expert witnesses
testimony in the legal system, 472–475
exposure techniques, 290–297
expressive writing, 401
external frame of reference, 276

external validity, 21
research results, 223
eye movement desensitization and reprocessing (EMDR)
controversy over use for PTSD, 296–297
Eysenck Personality Questionnaire (EPQ-R), 172, 178

face-to-face psychotherapy, 27
face-to-face treatment model
alternatives to, 60–61
face validity, 148
false memory cases, 495–496
family therapy, 239–240, 331–332
case example (Sal), 335–336
comparison with couples therapy, 337
diagnosis, 332
mental health service delivery, 331–337
methods, 334–335
multisystemic therapy, 335
social context, 336
FBI
criminal profiling, 466
Fear Survey Schedule (FSS), 171
fight-or-flight response, 396, 404
fluoxetine, 366
fluvoxamine, 366
forensic evaluations, 79–81
forensic psychiatry, 449
forensic psychology
advance medical directives, 464

Ake v. Oklahoma, 456
assessing competence to stand trial, 451–454
assessing psychological damage in tort cases, 461–462
assessing psychological status in civil cases, 461–464
assessing sanity, 455–457
child custody evaluations, 467–470
child custody mediation, 469–471
civil competency, 463–464
competence to stand trial, 450–454
correctional psychology, 449–450
criminal competence, 450–454
criminal profiling, 466–467
Cruzan v. Director, Missouri Department of Health, 464
definition, 448–449
diminished capacity defense, 460
Dusky v. United States, 451
end-of-life decisions, 464
expert witness role in insanity defense, 456–457
expert witness testimony, 472–475
Foucha v. Louisiana, 458
growth of, 448–449
guilty but mentally ill (GBMI) verdict, 454
insanity defense, 454–461
insanity defense reforms, 459–460
journals, 448
law enforcement psychology, 449
legal criteria for insanity, 454–455
malingering (faking mental illness), 456

meaning of ‘forensic’, 449
mens rea (‘guilty mind’), 454
Metrish v. Lancaster, 460
M’Naughton rule, 454–455, 458
not guilty by reason of insanity (NGRI) verdict, 454
physician-assisted suicide, 464
psychological autopsies, 464–466
psychology of litigation, 449
scope of, 449–450
Sell vs. United States, 453–454
termination of parental rights, 471
tort actions, 461–462
worker compensation cases, 462–463
Foucha v. Louisiana, 458
frame of reference, 276
frame-setting in interviews, 118–119
free association, 257
freedom-of-choice legislation, 498
frontotemporal degeneration (FTD), 436
fundamental anthropological condition (Adler), 264

Galton-Cattell sensorimotor tests, 35
general adaptation syndrome (GAS), 396–397
Geriatric Anxiety Inventory, 383
Geriatric Depression Scale (GDS), 383
Gerontological Society of America, 377
geropsychology. *See* clinical geropsychology
gestalt therapy, 279–281
attention to nonverbal behavior, 280–281

empty chair technique, 280
focus on the here and now, 280
frustrating the client, 281
role playing, 280
role-reversals, 280
unmailed letter technique, 280
Getting In: A Step-by-Step Plan for Gaining Admission to Graduate School in Psychology, 532
Goodenough Draw-A-Man Test, 41
Grade Point Average (GPA), 527–528, 539
graduate programs, 3
academic commitments, 523–525
admission credentials, 525–529
clinical experience, 526
extracurricular activities, 526–527
Grade Point Average (GPA), 527–528
Graduate Record Examinations (GRE) scores, 527
letters of recommendation, 528
realistic assessment of your credentials, 528–529
research experience, 525–526
undergraduate cousework, 525
applications, 529–549
admission offers, 548
APA accredited programs, 534
asking for letters of recommendation, 540–541
choosing a program, 530–534
costs of applications, 536–537
deadline to accept or reject an offer, 548

decision to accept or reject an offer, 548
financial aid for graduate study, 546–548
Graduate Record Examinations (GRE) testing, 537–539
importance of your Grade Point Average (GPA), 539
improving your chances of success, 548–549
letters of recommendation required, 539–540
main tasks involved, 529–530
number of applications to make, 535–536
PCSAS accredited programs, 534–535
personal interviews, 543–546
personal statement, 541–543
preparing for an onsite interview, 545–546
resources to help choose a program, 530–534
sources of information on, 530–534
testing involved, 537–539
timeline for the application process, 535
timing of applications, 535
viewing your letters of recommendation, 541
career goals and, 517–522
career information resources, 517
clinical emphasis, 517–518
commitment required, 520–525
doctoral degrees, 518–520
emotional commitments, 523–525
financial aid for graduate study, 546–548
financial commitments, 522–523
financial rewards after graduation, 524–525
job satisfaction of recent Ph.D. graduates, 524

MA degree, 518–520
Ph.D. degree, 518–520
Psy.D. degree, 518–520
research emphasis, 517–518
rights of psychology graduate students, 549
time commitments, 520–522
types of, 517–522
Graduate Record Examinations (GRE)
components of, 537–538
role in graduate program applications, 537–539
scores, 527
studying for, 538–539
Graduate Study in Psychology, 531
group therapy
altruism, 328–329
approaches to, 328
cognitive-behavioral group therapy, 329–330
definition, 328
group cohesiveness, 329
instilling hope, 328
interpersonal learning, 329
mental health service delivery, 328–331
practice of, 329
research on, 238–239
sharing new information, 328
therapeutic factors, 328–329
universality, 328
groups

self-help groups, 240
guided thoughts, 310–311

habituation, 290
Halstead–Reitan Neuropsychological Battery, 422, 435, 439, 445, 456
Hamilton Depression Symptom Questionnaire, 171
Handbook of Evidence-Based Practice in Clinical Psychology, 234
Handbook of Psychotherapy Integration, 510
Head Start program, 344
health care
managed care programs, 25–27
mental health parity, 25–27
health care environment, 25–28
Health Insurance Portability and Accountability Act (HIPAA), 494
health psychology, 394–403
adherence to medical treatment, 412–415
biopsychosocial model, 395
cardiovascular disease preventive interventions, 409
case example (Regina Bagdonas), 415–417
causes of non-adherence to medical treatment, 413–414
changes in the prevalent causes of death, 395–396
coping strategies, 399–400
definition, 394
developmental aspects of stress, 398
emergence as a specialty, 395–396
factors in psychological resilience, 400–401
general adaptation syndrome (GAS), 396–397
HIV/AIDS interventions, 410–412
hostility and cardiovascular disease risk, 406–408

illness prevention and treatment programs, 409–411
immune system and stress, 397–398
influence of demographic factors, 405–406
influence of social support, 401–403
influence of socioeconomic factors, 405–406
interventions for cancer patients, 410
interventions to improve adherence to medical treatment, 414
journals, 395
lifestyle-related damage to health, 395–396
long-term effects of childhood stress, 398
measuring stressors, 399
nervous system and stress, 396–398
pain management interventions, 409–410
professional organizations, 395
psychological risk factors for illness, 404
psychological risk factors in cardiovascular disease, 406–408
resilience factors, 399
risk factors for cardiovascular disease, 404–408
risk factors for illness, 403–408
role in prevention and treatment of illness, 396
role of stressors in cardiovascular disease, 404–406
stress, 396–398
stress-hardy personality characteristics, 400–401
transtheoretical model, 416–417
Type A behavior, 406
vulnerability factors, 399
Health Psychology, 394–403
hemineglect, 431–432

hemiparesis, 428
Hierarchical Taxonomy of Psychopathology (HiTOP), 61, 74
hippocampal sclerosis, 436
HIV/AIDS
  health psychology interventions, 410–412
Holden Psychological Screening Inventory (HPSI), 133
holistic treatments, 10
Home Observation for Measurement of the Environment (HOME), 132
homeopathy, 10
Hospital Anxiety and Depression Scale (HADS), 133, 383
hostility
  cardiovascular disease risk and, 406–408
House-Tree-Person test, 177, 360
Humana, 499
humanistic approach, 47–48
humanistic psychotherapy, 272–284
  current status of, 283
  emotion-focused therapy, 282–283
  existential therapy, 281–282
  features of, 272
  gestalt therapy, 279–281
  motivational interviewing, 282
  person-centered therapy, 272–279
hypergraphia, 433
hypnosis, 38, 252–253
hypothesis generation, 22
hysteria, 38

id (Freud), 46

illusory correlations, 92
immune system
effects of stress, 397–398
Implicit Association Test (IAT), 147
impression management, 126
Improving Access to Psychological Therapies (IAPT) program (UK), 326
incomplete sentence blanks, 360
incomplete sentence tests, 177
incongruence, 47, 273–274
incremental validity of assessment reports, 98–99
independent practice. *See* professional independence
independent variable, 220
individual differences
psychometric tradition, 33–35
individual psychology (Adler), 264–265
informed consent, 207
inpatient settings for psychotherapy, 200
insanity
legal criteria for, 454–455
insanity defense, 454–461
Insider's Guide to Graduate Programs in Clinical and Counseling Psychology, 532
insight
definition of, 202
fostering through psychotherapy, 202–203
goal of psychoanalysis, 46, 255
institutional review boards, 6
insurance providers

lists of psychotherapies they will cover, 22
managed care programs, 25–27
mental health parity, 25–27
intake interviews, 103–104
mental status examination (MSE), 103–104
integration of psychotherapy approaches, 24–25
integrative approach, 58–59
integrative behavioral couples therapy, 334, 510
integrative problem-centered therapy, 510
integrative techniques, 347
intelligence
characteristics of, 152
definition, 152
factor analytic models, 153
g (global, general ability), 152–153
general intelligence model, 152
hierarchical models, 153
multiple specific intelligences model, 152–153
psychometric approaches, 152–153
s (specific intellectual functions), 152–153
theories of, 152–153
triarchic theory of intelligence (Sternberg), 153
intelligence testing, 34–35
information-processing approach, 152
intelligence tests, 40–41, 152–165
Binet scales, 154–156
children, 359–360
clinical interpretation of test scores, 159

intelligence quotient (IQ), 154–156
Kaufman Assessment Battery for Children (K-ABC), 159–160
Kaufman Assessment Battery for Children (K-ABC-II), 161
Kaufman Brief Intelligence Test-2 (K-BIT-2), 160
Leiter International Performance Scale, 160
mental age, 154–155
Peabody Picture Vocabulary Test–Revised, 160
question of bias against certain groups, 162–165
Raven’s Progressive Matrices, 160
Stanford-Binet (SB5), 161
Stanford-Binet Intelligence Scale, 154–156
Wechsler Adult Intelligence Scale (WAIS), 156–157, 161
Wechsler-Bellevue Intelligence Scale, 156
Wechsler Intelligence Scale for Children (WISC), 156–159, 161
Wechsler Preschool and Primary Scale of Intelligence (WPPSI), 156–159
Wechsler scales, 156–159
Woodcock-Johnson Tests of Cognitive Abilities IV, 160
intensive short-term dynamic psychotherapy (ISTDP), 267–268
interdisciplinary science and practice
future trends, 510–511
interests
psychological tests, 165–167
internal consistency of tests, 83
internal frame of reference, 276
internal validity, 21
research results, 223
International Neuropsychological Society, 446
International Personality Disorder Examination (IPDE), 114

International Statistical Classification of Diseases and Related Health Problems (ICD), 70
International Statistical Classification of Diseases and Related Health Problems (ICD-11), 37, 61, 171
internet
influence on youth mental health, 373–374
internships, xxi, 7
Association of Psychology Postdoctoral and Internships Centers (APPIC), 484
shortage of internship slots, 484
interpersonal psychotherapy, 269–271
current status of, 270–271
history of, 269–270
treatment process, 270
interpersonal theory, 270
interpretation
definition of, 202–203
interpretation bias, 339
interprofessional relationships, 497–498
inter-rater reliability, 83, 125
observational assessment, 130
intersubjectivism, 266
interventions. *See* clinical interventions; psychotherapy
interviews
active listening, 119
client variance, 114
clinical interview situations, 103–111
clinical interviews of children, 359

crisis interviews, 106
criterion variance, 115
cultural issues, 107–110
debriefing interviews, 106
definition of interview, 102
direct questions, 112
doctor–patient interview schema, 120
ethical issues, 107–110
information variance, 115
intake interviews, 103–104
mental status examination (MSE), 103–104
older adults, 383
open-ended questions, 112
orientation interviews, 105
paraphrasing, 119–120
problem-referral interviews, 105
question of racial bias in psychological diagnosis, 107–109
reflection, 119–120
research on, 113–127
    communication and miscommunication, 124–125
    effects of clinicians' personal biases on assessments, 124–125
    reliability of interview data, 125–126
    threats to the value of interview data, 124–125
    validity of interview data, 125–127
setting, 117
sources of errors in data collection, 113–115
sources of further information on, 102–103
stage 1: beginning, 117–119

frame-setting, 118–119
opening the interview, 117–118
setting, 117
transition to the next stage, 118–119
stage 2: middle, 119–123
combining interview tactics, 122–123
directive techniques, 120–121
nondirective techniques, 119–120
nonverbal communication, 121–122
stage 3: closing the interview, 123
structure, 110–116
factors influencing the degree of structure, 112
nondirective interviews, 112
semistructured interviews, 112–113
structured interviews, 113–116
termination interviews, 106
use of behavioral incidents, 120
ipsative measurement, 149–171

Journal of Abnormal Child Psychology, 352
Journal of Alternative and Complementary Medicine, 348
Journal of American Geriatric Psychiatry, 378
Journal of Behavioral Medicine, 395
Journal of Child Psychology and Psychiatry, 352
Journal of Clinical Child and Adolescent Psychology, 352
Journal of Clinical Child Psychology, xxii
Journal of Clinical Psychology, xxi, 234
Journal of Community Psychology, 345
Journal of Consulting and Clinical Psychology, 43, 234

Journal of Consulting Psychology, 43
Journal of Family Psychology, 352
Journal of Latina/o Psychology, 234
Journal of Psychotherapy Integration, 25, 510
Journal of the American Academy of Child and Adolescent Psychiatry, 352
Journal of the American Geriatric Society, 378
Journals of Gerontology, 378

Katz Index of Independence in Activities of Daily Living, 383
Kaufman Assessment Battery for Children (K-ABC), 159–160
Kaufman Assessment Battery for Children (K-ABC-II), 161
Kaufman Brief Intelligence Test-2 (K-BIT-2), 160
Kaufman Test of Educational Achievement (K-TEA-3), 161
Kim alliance scale (KAS), 196
Kuder Occupational Interest Survey (KOIS), 165

Laboratory Parenting Assessment Battery (Lab-PAB), 133
language processing, 433
law enforcement psychology, 449
Lawton Instrumental Activities of Daily Living Scale, 383
leapfrog research design, 224
learning disorders, 444–445
learning principles
  behavioral approach to treatment, 48–49
legal requirements for clinical psychologists, 5–6
legal system. *See* forensic psychology
Leiter International Performance Scale, 160
Lewy body disease, 436
licensing board exam, 7

licensing of clinical psychologists, 5–6
licensure, 486–489
  reciprocity of, 488
Life's Simple 7 (AHA), 404–405
limbic-predominant, age-related TDP-43 encephalopathy (LATE), 436
litigation
  psychology of, 449
localization of function in the brain, 420–422, 424–425
Luria-Nebraska Neuropsychological Battery, 439–440
Luvox, 366

MacArthur Treatment Competence Study, 463
major neurocognitive disorder, 436
malingering, 126, 150
  faking mental illness for insanity defense, 456
malpractice litigation
  regulation of professional ethics, 495–496
managed care programs, 25–27, 498–499
mechanical prediction. See statistical prediction
mechanisms of change in psychotherapy, 59
Medicaid, 499
medical model of mental illness, 35–39
medical treatment
  adherence to, 412–415
  causes of non-adherence, 413–414
  interventions to improve adherence, 414
Medicare, xxii, 499
medication
  combining with psychotherapy, 241–242

memory
brain areas associated with, 433
mental age, 154–155
mental health literacy, 3, 513–514
Mental Health Parity Act (1996), 498
Mental Health Parity Act (2008), 498
Mental Health Parity and Addiction Act (MHPAA) (2008), 26
mental health parity in health care, 25–27
mental health professions, 3–8
mental health service delivery
access to care for children and adolescents, 372–373
alternatives to in-person therapy with mental health professionals, 328–329
challenges of dissemination and implementation, 325–326
clinical care delivery models, 325
community psychology, 345
complementary and alternative medicine, 347–348
couples therapy, 331–337
delivery methods, 213–214
dissemination and implementation of clinical interventions, 325–327
dissemination and implementation science, 324–325
eHealth models, 338–341
family therapy, 331–337
group therapy, 328–331
mHealth models, 338–341
new models of, 326–327
non-specialist providers, 341–342
paraprofessionals, 341–342
prevention science, 342–345

self-help methods, 346–347
sub-doctoral psychotherapy practitioners, 60
technology-based clinical services, 338–341
treatment delivery models, 27–28
treatment gap, 324–325
mental health services
effects of deinstitutionalization on patients, 60
reasons for underutilization of, 107
science-practice gap, 59–60
mental illness
burden of, 59–60
changing views over time, 35–39
ideas of Sigmund Freud, 38–39
supernatural explanations, 35–37
Mental Measurements Yearbook, 41, 144, 171
first publication, xxi
mental status examination (MSE), 103–104
mental testing movement, 34–35
meta-analytic studies, 228–230
Metadate, 366
methylphenidate, 366
Metrish v. Lancaster, 460
mHealth models, 338–341
Miller Analogies Test, 41
Millon Clinical Multiaxial Inventory (MCMI-IV), 171, 177
mindfulness, 316–318
mindfulness-based cognitive therapy, 317
mindfulness-based stress reduction, 317

Mini-Cog, 385
Minnesota Multiphasic Personality Inventory (MMPI)
first publication, xxi
Minnesota Multiphasic Personality Inventory (MMPI-2), 456, 468
Minnesota Multiphasic Personality Inventory (MMPI-2-RF), 168–169, 177
mirror neurons, 197, 510
M’Naughton rule, 454–455, 458
Montreal Cognitive Assessment, 385
motivational interviewing, 282
multicultural competence, 503–509
APA guidelines, 503–505
case study (Alejandro Alvarez), 507–508
clinical assessment, 87–88
clinical interviewing, 107–110
culturally-adapted treatment, 505
effect on therapy outcomes, 505–507
openness to the other, 503
See also cultural competence, 508
multiculturalism
clinical child psychology, 371–372
clinical geropsychology, 391
Multidimensional Personality Questionnaire (MPQ), 172
multisystemic therapy, 239, 335
Myers-Briggs Type Indicator (MBTI), 174–178

naïve realism, 235
National Association of School Psychologists, 518
National Association of Social Workers, 518
National Center for Complementary and Alternative Medicine, 347

National Comorbidity Survey Replication, 188
National Council on Measurement in Education, 181
National Institute of Clinical Excellence (NICE), 233
National Institute of Mental Health, 42
    Prevention Intervention Research Centers (PIRCs), 344
National Institute on Aging (NIA), 377
National Register of Health Service Providers in Psychology, xxii, 488–489
naturalistic observation, 131–134
negative attributional style, 305–306
NEO Personality Inventory (NEO-PI-3), 173, 178
nervous system
    effects of stress, 396–398
neuropsychological assessment, 438–441
    approaches to, 438–439
    Halstead–Reitan Neuropsychological Battery, 439
    individualized approaches to testing, 440–441
    Luria-Nebraska Neuropsychological Battery, 439–440
    neuroplasticity, 441
    rehabilitation, 441
    test batteries, 439–440
neuropsychology
    abulia, 435
    akinetic mutism, 435
    anosognosia, 428–430
    approaches to psychopathology, 442–445
    attention deficit/hyperactivity disorder (ADHD), 444
    basic principles, 424–430
    behavioral manifestations of brain dysfunction, 431–438

blindness, 431
blindsight, 431
brain modularity, 425–426
clinical case (Ellen Yang), 418–419
current status of, 446–447
definition, 419
dementia, 436–437
depression, 442–443
development of assessment techniques, 422
developmental disorders, 444–445
dyslexia, 444
early influences, 420–422
echolalia, 435
echopraxia, 435
ectopias (misplaced cells) in the brain, 444
equipotentiality, 421
executive function deficits, 434–435
frontal lobe dysfunction, 434–435
hemineglect, 431–432
history of, 420–424
Houston conference training guidelines, 446
hypergraphia, 433
knowledge and skills required, 419–420
language processing, 433
lateralization of brain function, 426–428
learning disorders, 444–445
left hemisphere specialization, 426–427
levels of interaction in the brain, 426

localization of function, 420–422, 424–425
major neurocognitive disorder, 436
memory disruption, 433
networks in the brain, 425–426
neuropsychological syndromes, 435–437
nonverbal learning disorder (nonverbal disability), 444–445
occipital lobe dysfunction, 431
palinopsia, 431
parietal lobe dysfunction, 431–432
patterns of brain dysfunction, 431–438
perseveration, 434–435
phrenology, 420–421
prosopagnosia caused by brain damage, 422
research on normal brains, 423
right hemisphere specialization, 427–428
schizophrenia, 443–444
school-related attention, memory, and language problems, 444
scope of the field, 419
simultanagnosia, 432
split-brain research, 423
temporal lobe dysfunction, 432–434
temporal lobe epilepsy (TLE) personality, 433–434
visual agnosia, 432–433
work of Paul Broca, 421–422
nondirective interviews, 112, 119–120
nonverbal communication, 121–122
nonverbal learning disorder (nonverbal disability), 444–445
Nurses Observation Scale for Inpatient Evaluation (NOSIE), 132

object relations therapy, 265–266
observational assessment
approaches, 131–137
behavioral avoidance tests, 136–137
controlled observation, 131, 134–137
naturalistic observation, 131–134
participant observers, 132–133
performance measures, 134–135
phallometric measurement, 136
physiological measures, 135–136
role-playing tests, 135
self-observation, 133
virtual reality assessment, 136
calibrating, 130
children, 360–361
corroborating measures, 133–134
ecological validity, 129
goals of, 128–129
inter-rater reliability, 130
limitations of, 130
non-participant observers, 131
observational methods, 128
participant observers, 131
predictive validity, 140
research on, 138–141
defining observational targets, 138
reliability of observed behavior, 139
representativeness of observed behavior, 138–139

situational bias, 138–139
validity of observational assessment, 140
situational determinants of behavior, 129
sources of further information on, 102–103
structured observations, 128–130
supplementing self-reports, 129
threats to the value of observational data, 130
unobtrusive measures, 133–134
observational learning, 287
Office of Strategic Services (OSS) (later the CIA)
situational tests, 134
older adults. *See* clinical geropsychology
open-ended questions, 112
operant conditioning, 48–49, 287
Operational Stress Test, 134
oppositional defiant disorder (ODD)
psychosocial treatments, 364–366
orientation interviews, 105
Outcome Questionnaire-45 (OQ-45), 182
outpatient settings for psychotherapy, 199–200
outreach to the national and international communities, 514
oxytocin, 197

pain management
health psychology interventions, 409–410
palinopsia, 431
Panic Disorder Severity Scale, 171
paraprofessionals, 10
parent–child interaction therapy, 239, 335

parent management training, 239, 335–336
parental rights
termination of, 471
pastoral counselors, 10
Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (2008), 498
Paul Wellstone Mental Health and Addiction Equity Act (2007), xxiii
Peabody Picture Vocabulary Test–Revised, 160
Penn State Worry Questionnaire, 383
Pennsylvania (Penn) Scales, 196
Perceived Stress Scale (PSS), 399
performance measures, 134–135
performance prediction, 79
perseveration, 434–435
person-centered therapy, 272–279
case example (James Jackson), 277–279
conditions of worth, 273
congruence, 277
empathy, 275–277
goals of, 274–277
incongruence, 273–274
nature of change in, 277
reflection, 276–277
unconditional positive regard, 274–275
personal characteristics of clinical psychologists, 5
personal construct theory (Kelly), 49
Personal Data Sheet, 41, 168
personality

definition, 167
stress-hardy personality characteristics, 400–401
Personality Assessment Inventory (PAI), 169–171, 177
Personality Inventory for the DSM-5 (PID-5), 171
personality tests, 167–178
objective tests, 171–174
projective tests, 174–177
types of, 167–168
personalization, 50
pharmacological interventions
children and adolescents, 366–368
older adults, 389
phenomenological therapies, 47
phenomenology, 47
phobias
behavioral avoidance tests, 136–137
phrenology, 34, 420–421
physician-assisted suicide, 464
physiological measures of responses, 135–136
Pikes Peak Model, 379
placebo-control research design, 222
placebo effect, 204
positive psychology, 400
approach to diagnosis, 74
building resilience, 370
future trends, 511
postmodernism, 266
posttraumatic growth, 511

post-traumatic stress disorder (PTSD)
  controversy over EMDR treatment, 296–297
potentially harmful therapies (PHTs), 233
practicum courses, 7
practitioner–scholar model, 24, 483
prediction
  clinical versus statistical prediction, 92–94
  in clinical psychology, 77–81
predictive validity, 84, 126
preferences
  psychological tests, 165–167
prescription privileges, xxii, 27, 499–500
presenting problem, 65
prevention science, 342–345
  changing environments, 344
  indicated prevention intervention, 343
  prevention programs, 344–345
  primary prevention, 344
  promoting empowerment, 344–345
  reducing stress, 344
  secondary prevention, 343
  selective mental health prevention, 343
  terminology, 342–344
  tertiary prevention, 343
  universal mental health prevention, 344
preventive interventions
  research on, 240
principles of change, 58

prisons
inmates with mental health issues, 60
problem-focused coping, 399–400
problem-referral interviews, 105
professional ethics, 490–491, 496
APA ethical standards, 490–491
dealing with ethical violations, 492–493
duty to warn, 494–495
ethical standards, 490–491
ethical standards for particular situations, 493–494
examples of potentially unethical behavior, 492
false memory cases, 495–496
HIPAA regulations, 494
implementation of ethical standards, 492
reasons for disciplinary action against psychologists, 493
regulation through malpractice litigation, 495–496
regulation through state law, 494–495
Tarasoff vs. Regents of the University of California, 494–495
See also ethical issues
professional independence, 497–502
economics of mental health care, 498–499
financial rewards for independent service providers, 499
independent practice, 499
interprofessional relationships, 497–498
models of independent practice, 499
parity for mental health care provision, 498–499
prescription privileges, 499–500
reimbursement rates, 499

professional organizations
  formation by clinicians, 43–44
Professional Psychology, xxii
professional regulation, 486–490
  ABPP certification, 489
  certification, 486–489
  continuing education (CE), 488
  Examination for Professional Practice in Psychology (EPPP), 486–487
  licensure, 486–489
  purpose of, 486
  reciprocity of licensure, 488
professional training, 478–485
  accreditation systems, 480–482
  Boulder Conference (Colorado, 1949), 479
  Boulder model, 479
  clinical scientist model, 483–484
  current status, 480–482
  Delaware Conference (2011), 480
  Delaware Project, 480
  Doctor of Psychology (Psy.D.) degree, 482–483
  doctoral degrees, 480
  eclecticism and integration, 24–25
  evaluating clinical psychology training, 484
  future trends, 510
  influence of the Shakow Report (1947), 478–479
  internship imbalance, 484
  master's (MA) degrees, 480
  PCSAS accreditation, 481–482

practitioner–scholar model, 483
professional schools, 482–483
Salt Lake City Conference (Utah, 1987), 480
scientist–practitioner model, 483
scientist–professional model, 479
training models, 23–24, 483–484
Boulder model, 23–24
clinical science model, 24
practitioner–scholar model, 24
scientist–practitioner model, 23–24
Vail model, 24
Vail Conference (Colorado, 1973), 479–480
Profile of Mood States, 171
prognosis, 77–79
progressive muscle relaxation (PMR), 291
progressive relaxation training (PRT), 291–292
projective hypothesis (Freud), 174
projective tests
children, 360
prosopagnosia, 422
Prozac, 366
PsyberGuide.org, 240, 349
psychiatric aides, 10
psychiatric nurses, 10
psychiatry, 9–10
psychic determinism, 254
psychoanalysis, 241–247
case example (Lena Jackson), 255–261

cathartic method, 252–253
countertransference, 254
defense mechanisms, 250–252
definition, 253
dream analysis, 258–259
foundations of psychoanalytic therapy, 252–255
free association, 253, 257
Freud's theory of personality and psychopathology, 249–252
hypnosis, 252–253
id, ego, and superego, 249–250
insight, 255
interpretation, 255
intrapsychic conflict, 250
levels of human consciousness, 249–250
psychic determinism, 254
resistance to treatment, 254–259
structural model of the mind, 249–250
topographical model of the mind, 249
transference, 253–254
transference neurosis, 259
working through, 255
psychoanalytic psychotherapy, 255
psychoanalytic theory, 45
psychodiagnosis, 70
psychodynamic approach, 45–47
Psychodynamic Diagnostic Manual (PDM), 74
psychodynamic psychotherapy, 263–269
analytical psychology (Jung), 265

current status of, 268
definition, 264
ego psychology, 265
individual psychology (Adler), 264–265
intensive short-term dynamic psychotherapy (ISTDP), 267–268
object relations therapy, 265–266
relational psychodynamic psychotherapy, 266–267
short-term psychodynamic psychotherapy, 267–268
psychoeducation, 309
psychological assistants, 10
psychological autopsies, 465–466
Psychological Clinical Science Accreditation System (PCSAS), 481–482
accredited graduate programs, 534–535
psychological resilience
factors in, 400–401
psychological risk factors for illness, 404
psychological testing
achievement tests, 160–161
analytical (rational) approach to test construction, 146–148
applicability to diverse clients, 180–181
aptitude tests, 160–161
attitude tests, 165–167
avoiding distortion in test scores, 150
basic concepts, 144–151
client response set/bias/style, 150
clinical utility of tests, 182
construction of tests, 146–149
criterion-referenced tests, 149

culture-specific effects, 180–181
current status of, 178–183
definition of a psychological test, 145–146
empirical approach to test construction, 147–148
ethical use of psychological tests, 181
expansion of, 40–41
factors that can influence test results, 150
features of psychological tests, 145–146
future trends, 182–183
history of use, 143–144
intelligence testing, 152–165
interests tests, 165–167
ipsative measurement, 149–171
malingering by clients, 150
new roles and goals for tests, 182–183
norm-referenced tests, 149
personality tests, 167–178
preferences tests, 165–167
psychopathology tests, 167–178
range of tests available, 144
reliability of tests, 179–180
re-norming of tests, 149
score interpretation, 149–171
sequential system approach to test construction, 148–149
social desirability bias in clients, 150
sources of information on tests, 144
standardization, 149–171
standardization sample, 149

validity of tests, 179–180
values tests, 165–167
what tests measure, 144
psychology
specialized subfields, 8
Psychology and Aging, 378
Psychology as a Behaviorist Views It (Watson), xxi
psychology of litigation, 449
psychometric tradition, 33–35
psychometricians, 83
psychoneuroimmunology, 398
Psychoneurotic Inventory, 41, 168
psychopathology
biopsychosocial approach, 52
diathesis-stress model, 52–53
psychopathology tests, 167–178
objective tests, 174–177
types of, 167–168
Psychopathy Checklist (PCL-R), 114
Psychopathy Checklist–Revised (PCL-R), 456
psychosocial treatments
children and adolescents, 364–366
Psychosomatic Medicine, 395
psychotherapists
boundary challenges, 212
challenges faced by, 193–194
challenges to therapists’ values, 207–208
characteristics, 190–195

characteristics of effective therapists, 190–192
influence of training and experience, 191–193
objectivity, 212
personal and interpersonal skills, 190–192
question of psychotherapy for, 194–195
self-disclosure, 212
self-monitoring, 191
psychotherapy
acceptance-based therapy, 314–322
assigning extra-therapy tasks (homework), 203
behavior therapy, 286–302
case formulation (case study guide), 210–212
challenges to therapists' values, 207–208
client characteristics, 188–190
client factors in treatment outcomes, 188–190
clinical utility focus, 213
cognitive-behavior therapy (CBT), 314–322
cognitive therapy, 302–314
defintion of, 186
developing faith, hope, and expectations for change, 203–204
development of, 41–42
ethical guidelines, 205–209
fees, 209–210
for psychotherapists, 194–195
fostering insight, 202–203
goals of, 201–205
humanistic psychotherapy, 272–284
influence of therapist characteristics, 190–195

inpatient settings, 200
integration of approaches, 24–25
interpersonal psychotherapy, 269–271
mental health service delivery methods, 213–214
outpatient settings, 199–200
overview, 185–187
practical aspects, 209–214
premature termination of therapy, 212–213
prevalence of different disorders, 188
providing new information (education), 203
psychoanalysis, 248–263
psychodynamic psychotherapy, 263–269
public (mis)perception of, 186
range of approaches to, 186–187
record keeping, 210
reducing emotional discomfort, 202
settings for, 199–201
sub-doctoral practitioners, 60
termination of therapy, 212–213
therapeutic alliance, 195–199
therapist objectivity, 212
therapist self-disclosure, 212
treatment duration, 209–210
treatment planning, 210–211
treatment utilization issues, 188
trends in, 213–214
use of treatment manuals, 244–245
psychotherapy integration

future trends, 510
Psychotherapy Relationships That Work, 235
psychotherapy research, 13–15
additive designs, 223
attention-control design, 222
between-subjects research designs, 220–224
bona fide interventions, 223
box score reviews, 227–228
case-study model, 221
client satisfaction surveys, 227
clinical significance of results, 219–220
combination of psychotherapy and medication, 241–242
common factors in successful therapy, 235–237
CONSORT standards for RCTs, 224–225
couples therapy, 239
dependent variable, 220
dismantling designs, 223
dissemination and implementation, 325–327
dissemination and implementation of research results, 244–245
effect size statistic, 228
effectiveness of treatments, 219
efficacy of treatments, 219
empirically-supported treatments (ESTs), 230–233
evidence-based practice, 217–218, 233–235
experimental designs, 219–224
external validity of results, 223, 243–244
family therapy, 239–240
group therapy, 238–239

history of outcome research, 218–219
independent variable, 220
influence of non-specific and common factors, 244
internal validity of results, 223, 243–244
issues and concerns about, 243–246
leapfrog design, 224
meta-analytic studies, 228–230
nonspecific (placebo) effects of therapy, 222
placebo-control design, 222
potentially-harmful therapies (PHTs), 233
preventive interventions, 240
randomized controlled trials (RCTs), 223–224
results of research on individual treatments, 227–238
self-help groups, 240
self-help resources, 240
SMART study designs, 224
spontaneous remission rates, 218
statistical significance of results, 219–220
study designs, 219–224
study methods, 218–226
therapeutic alliance, 236–237
translational research, 502–511
use of treatment manuals, 244–245
within-subjects research designs, 220–221
Psychotherapy Status Report (PSR), 196
PsycTESTS database, 144

questions
direct questions, 112

open-ended questions, 112

randomized controlled trials (RCTs), 223–224
CONSORT standards, 224–225
rational-emotive behavior therapy (Ellis), 50–51, 308–309
Raven's Progressive Matrices, 160
record keeping, 210
recovered memory therapies, 233
referral question, 65–66
referral source, 65
reflection
person-centered therapy, 276–277
reflexology, 10
regulation of clinical psychology. *See* professional regulation
Rehabilitation Act (1973), 498
relational disorders, 72
relational psychodynamic psychotherapy, 266–267
reliability
clinical assessment instruments, 83
inter-rater reliability, 125
interview data, 125–126
observational assessment, 139
psychological tests, 179–180
test-retest reliability, 125
religion
pastoral counselors, 10
supernatural explanations for mental illness, 35–37
repression, 46
research. *See* psychotherapy research

Research Domain Criteria (RDoC), 61, 74–75
resilience
  building in children, 370
  factors in psychological resilience, 400–401
Rey Complex Figure Test and Recognition Trial, 385
Ritalin, 366
Roberts Apperception Test for Children (RATC), 177
Rogers Criminal Responsibility Assessment Scale (RCRAS), 114
Rokeach Value Study (RVS), 165–167
role playing
  gestalt therapy, 280
role-playing tests, 135
Rorschach Inkblot Test, 41, 174–176, 178, 456
Rosenzweig Picture-Frustration Study, 176
Rotter Incomplete Sentences Blank, 177

salaries of clinical psychologists, 17
Salt Lake City Conference (Utah, 1987), 480
SAT (Scholastic Aptitude Test), 160–161
Schedule for Affective Disorders & Schizophrenia (SADS), 114
Schedule of Recent Experiences (SRE), 399
schemas, 303–304
schizophrenia, 37, 49, 72, 133–134, 240, 453
  negative symptoms, 443
  neuropsychological approach, 443–444
  positive symptoms, 443
school psychology, 8–9
science and practice, 20–24
science-practice gap in mental health services, 59–60

scientific attitude, 5
scientific thinking, xviii, 5
ability of clinicians to predict dangerous behavior, 79–81
assessing evidence, 21
cognitive bias modification (CBM), 339–341
comparing effectiveness of different therapies, 228–230
controversy over EMDR for PTSD, 296–297
effect of cultural competence on therapy outcomes, 505–507
evaluating technology-based interventions, 339–341
evidence for anosognosia, 428–430
hostility and cardiovascular disease risk, 406–408
implications of insanity defense, 457–459
intelligence test bias against certain groups, 162–165
lack of awareness of neurological deficit, 428–430
psychotherapy for psychotherapists, 194–195
question of racial bias in psychological diagnosis, 107–109
relevance of Freud's insights, 261–262
risks and benefits of medication for child and adolescent disorders, 367–368
theoretical approaches to clinical psychology, 56–59
scientist–practitioner model, 23–24, 44, 483
scientist–professional model, 479
Seashore Measures of Musical Talents, 161
selective serotonin reuptake inhibitors (SSRIs)
prescribing for children and adolescents, 366
self-actualization, 47, 273
Self-Directed Search (SDS) test, 165
self-help groups, 240

self-help methods, 346–347
self-help resources, 240
Self-Help That Works: Resources to Improve Emotional Health and Strengthen Relationships, 240
self-observation, 133
self-reports
  older adults, 383–384
  supplementing with observational assessment, 129
Sell vs. United States, 453–454
Semistructured Clinical Interview for Children and Adolescents, 359
semistructured interviews, 112–113
Sequential, Multiple Assignment, Randomized Trial (SMART) study designs, 224
sertraline, 366
Shakow Report (1947), xxi, 478–479
short-term psychodynamic psychotherapy, 267–268
signs (of disorder), 37
simultanagnosia, 432
situation tests, 134
situational determinants of behavior, 129
social imitation, 48–49
social skills training, 297–298
social support
  influence on health, 401–403
social systems approaches, 51–52
social work, 9
Society for Clinical Geropsychology, 377
Society for Humanistic Psychology, 72

Society of Behavioral Medicine, 395
Society of Clinical Child and Adolescent Psychology, 244, 352, 366
Society of Clinical Psychology, 230, 232, 244
Society of Pediatric Psychology, 352
socioeconomic factors
  influence on health, 405–406
Socratic questioning, 310–311
spiritual healing, 10
spirituality
  role in clinical psychology, 511–512
split-half reliability of tests, 83
spontaneous remission rates, 218
standardization of assessment methods, 85
Stanford-Binet (SB5), 161
Stanford-Binet Intelligence Scale, 35, 154–156, 456
Stanford-Binet Intelligence Test
  first publication, xxi
state boards of psychology, 486
state laws
  regulation of professional ethics, 494–495
statistical prediction versus clinical prediction, 92–94
statistical significance of results, 219–220
Sternberg Triarchic Abilities Test (STAT), 153
stress, 396
  coping strategies, 399–400
  developmental aspects, 398
  diathesis-stress model, 52–53
  fight-or-flight response, 396

general adaptation syndrome (GAS), 396–397
immune system effects, 397–398
influence of social support, 401–403
long-term effects of childhood stress, 398
measuring stressors, 399
nervous system effects, 396–398
resilience factors, 399
role of stressors in cardiovascular disease, 404–406
stress-hardy personality characteristics, 400–401
vulnerability factors, 399
Stress in America survey, 397–398
Strong Interest Inventory (SII), 165
Strong Vocational Interest Inventory, 166
Strong Vocational Interest Test, 41
structural family therapy, 239
Structured Clinical Interview for DSM-5 Disorders (SCID-5), 114, 383
Structured Clinical Interview for Personality Disorders (SCID-5-PD), 114
structured interviews, 113–116
Studies in Hysteria (Breuer and Freud), xxi
Study of Values (SoV), 165–167
substance use disorders, 72
suicide
physician-assisted, 464
superego (Freud), 46
symptoms, 37
syndromes, 37
systematic desensitization, 290–291

Tarasoff vs. Regents of the University of California, 494–495

task-shifting programs, 213
teaching activities of clinical psychologists, 15
technical eclecticism, 25
technology
  future roles in clinical psychology, 512–513
  role in clinical geropsychology, 391–392
  youth mental health and, 373–374
technology-based clinical services, 338–341
telepsychology, 512–513
temporal lobe epilepsy (TLE), 433–434
termination interviews, 106
testing. *See* psychological testing
test-retest reliability, 83, 125
The Benefits of Psychotherapy (Smith, Glass, and Miller), xxii
The Handbook of Positive Psychology Assessment, 74
The Psychological Clinic, xxi
Thematic Apperception Test (TAT), xxi, 41, 176, 178, 360, 456
theoretical approaches
  eclecticism and integration, 24–25
theoretical eclecticism, 25
therapeutic alliance, 195–199
  avoiding or repairing a rupture, 198–199
  definition, 195–196
  instruments for measuring, 196
  promoting a strong alliance, 198–199
  research on, 196–197, 236–237
  views of, 196
Therapeutic Bond Scales, 196

Therapist Cultural Comfort Scale, 110
thinking scientifically. *See* scientifc thinking
thought records, 311–312
TLE personality, 433–434
Toronto Scales, 196
training in clinical psychology. *See* graduate programs; professional training
transcranial magnetic stimulation (TMS), 441
transdiagnostic approaches, 59
transference, 253–254
transference neurosis, 259
transtheoretical model, 416–417
treatment. *See* clinical interventions; psychotherapy
treatment gap, 324–325
Treatment Outcome Package (TOP), 133
trephining, 36
triarchic theory of intelligence (Sternberg), 153
Type A behavior, 406

unconditional positive regard, 274–275
United States Army
    recruitment assessment tests, 41
United States Government
    Bureau of Labor Statistics, 518
    Department of Veterans Affairs, 42, 233
    Public Health Service, 42
unmailed letter technique, 280

Vail Conference (Colorado, 1973), 479–480
Vail model of training, 24

validity
  convergent validity, 126
  discriminant validity, 126
  external validity of research results, 223
  face validity, 148
  internal validity of research results, 223
  internal-external validity issue, 243–244
  interview data, 125–127
  of assessment methods, 83–85
  predictive validity, 126, 140
  psychological tests, 179–180
values
  challenges to psychotherapists' values, 207–208
  psychological tests, 165–167
Values in Action (VIA) Classification of Strengths: The un-DSM and the Real DSM (Peterson), 74
Vanderbilt Psychotherapy Process Scale, 196
vascular dementia, 436
Veterans Administration. *See* United States Government, Department of Veterans Affairs
vicarious conditioning, 287
Vineland Training School, xxi
virtual reality assessment, 136
visual agnosia, 432–433
Vyvanse, 366

Wada task, 426–427
Washington University Sentence Completion Test, 177
Ways of Coping questionnaire, 512

Wechsler Adult Intelligence Scale (WAIS), xxii, 156–157, 161, 385, 456
Wechsler-Bellevue Intelligence Scale, 41, 156
Wechsler-Bellevue Intelligence Test
    first publication, xxi
Wechsler Individual Achievement Test (WIAT-III), 161
Wechsler Intelligence Scale for Children (WISC), 156–159, 161, 360
Wechsler Memory Scale, 434
Wechsler Preschool and Primary Scale of Intelligence (WPPSI), 156–159
Wechsler scales, 156–159
Wide Range Achievement Test (WRAT5), 161
will therapy, 272
Wisconsin Card Sorting Test, 435, 443
within-subjects research designs, 220–221
Woodcock-Johnson Tests of Achievement IV, 161–162, 360
Woodcock-Johnson Tests of Cognitive Abilities IV, 160–161
Word Association Test (Jung), 41
work settings of clinical psychologists, 16–17
Working Alliance Inventory, 196
World War I, 41
World War II
    need for clinical psychologists, 42

Zoloft, 366