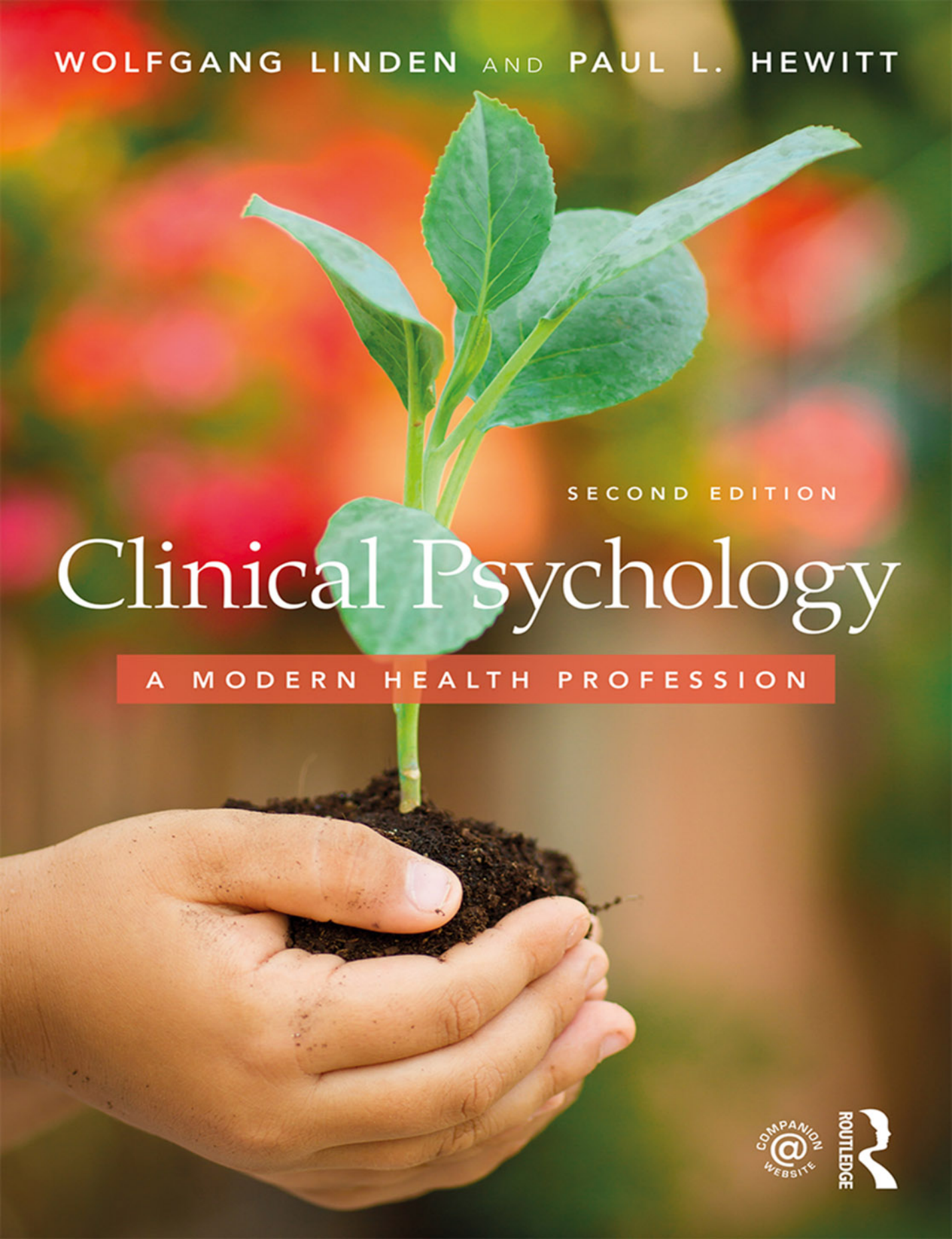
WOLFGANG LINDEN AND PAUL L. HEWITT
SECOND EDITION
Clinical Psychology
A MODERN HEALTH PROFESSION
COMPANION @ WEBSITE
ROUTLEDGE

Clinical Psychology

Clinical Psychology invites students to think like clinical psychologists and develop an integrated sense of how science, experience, ethical behavior, and intuition get woven into our professional identity. Built around typical psychologists and the problems they need to solve, it demonstrates that assessment is much more than testing, and explores how treatment rationales are tailored to the individual problems, histories, and environments of clients. Committed to training future professionals, this text navigates students through the career path of a clinical psychologist and provides guidance on evolving education and training models.

The text uniquely portrays clinical psychology as a modern health care profession that bridges physical and mental health and takes a holistic stance. It treats therapy as a dynamic process that benefits from the cross-fertilization of a range of different approaches. It also provides an international perspective, describing similarities and differences between how clinical psychology is practiced in different countries and contexts. It recognizes that clinical psychology changes as health care systems change, and stresses that training models and practice patterns need to match these changes.

This second edition has been fully revised and reflects *DSM-5* and *ICD-10-CM* guidelines. New and enhanced features include:

- Additional description of the continuing integration of therapy approaches
- Additional evidence on how to make psychotherapy cost-effective
- Upgrades on self-help and web-based treatment
- An expanded chapter on psychopharmacology, offering more information on mechanisms
- Expanded in-text pedagogy, offering more vignettes, ongoing considerations, key terms, and thinking questions
- PowerPoint slides and links to recommended resources.

Wolfgang Linden is Professor in Clinical and Health Psychology at the University of British Columbia with expertise in bridging clinical psychology and physical health applications. He has been very active in professional governance and advocacy for improved mental health care for over three decades.

Paul L. Hewitt is Professor in Clinical Psychology and a member of the Psychotherapy Division at the University of British Columbia. He is also a practicing clinical psychologist in Vancouver, Canada.

"The first edition of *Clinical Psychology: A Modern Health Profession* by Wolfgang Linden and Paul L. Hewitt was my first choice as a textbook. This second edition is now my first choice. Linden and Hewitt have used their extensive clinical knowledge to write a contemporary classic that describes how the vast psychological knowledge drawn from theory and research can inform and be integrated into evidence-based clinical practices from assessment to intervention. This is a dynamic and engaging book that will resonate with students, clinical trainers, and practicing psychologists."

—**Don Saklofske**, *University of Western Ontario, Canada*

"Linden and Hewitt's new edition substantively improves upon an already exceptional primer for students exploring the complexities of a career in clinical psychology. With sensitivity to both foundational principles as well as contemporary forces shaping the field, this new edition clearly outlines the essential role of clinical psychology in modern healthcare. It represents an invaluable resource to any clinical prep or field orientation course."

—**William S. Chase**, *Keystone College, USA*

Clinical Psychology

A Modern Health Profession

Second Edition

Wolfgang Linden and Paul L. Hewitt

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Preface

This is Edition II of a textbook for which the writing of Edition I was completed in 2010. The extensive changes were guided by a set of very helpful anonymous reviews coming from 13 different professors who teach this material elsewhere. We are deeply indebted to them as individuals and their joint wisdom. They also made our job easy because there was great overlap in their views in that the first edition was seen as comprehensive, well-sequenced, and at a suitable reading level. The reader will find first a listing of changes and upgrades. Then we largely repeat the contents of the Foreword for Edition I because our overall approach was meant to be unique and a reflection of who we, the authors, are and how we see our profession (. . . and we have changed little since then).

Friends and colleagues graciously read and commented on revised material. We thank Christian Schütz, MD, PhD, MPH for his critical reading of our material on Psychopharmacology. As well, we had several psychology students read the documents and give us feedback from students' perspective. In particular we thank Briana Smirfitt and Ariel Ko for their comments and suggestions. We would also like to thank Barbara Calvert who provided some original artwork for this book.

How does Edition II differ from the first?

- Updated references, tables, and figures to accommodate 7–8 years of additional publications.
- More information on training and career paths for Master's level trained practitioners.
- Additional description of the continuing integration of therapy approaches, further search for commonalities, and more emphasis on cognition.
- Offered is additional evidence on how to make psychotherapy cost-effective.
- Upgrades are offered on self-help and web-based treatment.
- The chapter on psychopharmacology was expanded to offer more information on mechanisms.
- Some treatments that were categorized as innovative and only partly tested (namely mindfulness meditation and acceptance and commitment therapy) are now seen as mainstream and were moved into the appropriate chapter (Chapter 12).
- For additional pedagogy we open each chapter with bulleted objectives.
- We added original artwork and some photos for visual enrichment.

We are not sure whether it can (or should) be called "remarkable" but . . . many topics and domains have seen relatively little change since 2010:

- Ethics principles and conflict resolution strategies are similar.
- Major struggles continue around health care system changes and the need to develop a more chronic disease and lifespan approach.
- Psychotherapy effectiveness is continuously affirmed.

- The basic underlying rationales, methods, and their limitations in assessment continue to exist even though tests are upgraded to newer versions and validity evidence keeps growing. Questionnaires and interviews continue to dominate whereas the promise and advantages of ambulatory, in-vivo assessments with sophisticated electronics are mainly used in research but not in routine clinical practice.

What was Edition I like and how did it get to be? The decision to write this textbook in its first edition had stemmed from Wolfgang Linden's experience of more than two decades of teaching a 4th-year undergraduate, introductory "Clinical Psychology" course, and from many conversations with representatives from college textbook publishers who just could not provide the kind of text he was seeking for his class. Of course, the textbook publishers' representatives who came to the university campus routinely said: "Why don't you write a textbook yourself that suits your needs?" As the existence of this book (now in Edition II) in your hands proves, the dam broke and two authors with complementary areas of expertise in clinical psychology joined forces to do just that. Paul Hewitt also believed that many of the existing clinical psychology textbooks missed critically important aspects of contemporary clinical and research work and revealed a sometimes not-so-subtle bias against particular domains of clinical inquiry. Hence, the authors decided to try to create a textbook that addressed the missing components. Moreover, the authors wished to provide an international flavor to the textbook so as to teach students about the larger field of clinical psychology, not the field of clinical psychology as it is narrowly practiced in any one country or jurisdiction. In the end, this was not particularly difficult because the similarities of the field between countries greatly outweigh the differences. However, at times, there are emphases on certain aspects of the field that different countries promote, and practitioners in different countries can inspire each other by sharing their knowledge. The fact that clinical psychology is embedded in country-specific systems of health care delivery also allows comparisons and identification of innovative strategies that may invite application elsewhere for the benefit of better patient care.

Why could we not find another book that satisfied our needs? There are many reasons. First of all, both WL and PH considered existing texts too narrow in their coverage and at times presenting somewhat antiquated views of the field. Also, a predominant habit of existing texts in clinical psychology books is to "start at the beginning," with a lengthy chapter on history. While we agree that it is important to understand the roots and the context for developments in clinical psychology, we think that more curiosity is raised in students by starting **today**, by appreciating what kinds of problems clinical psychologists solve every day, and by delineating the satisfactions that they derive from their work. This presentation of day-to-day realities sets the stage for appreciating the tools needed to complete the daily tasks and solve problems. To make this approach come alive, we present these tools, work our way through ethical considerations, assessment and treatment issues, deal with what works in therapy and what does not, and raise questions about where the future may take us. The objective of this book is not just to teach facts about clinical psychology but to encourage the student to think like a clinical psychologist, to develop an integrated sense of how science, experience, ethical behavior, and intuition get woven into our professional identity.

By attempting to make clinical psychology "real" and timely, we are seeking to arouse curiosity in the readers so that they truly want to move through the text and find the answers, just like in a good thriller where you will want to find out who did it, and why, and "how the gardener almost got away with murder"!

What else makes this book different?

- We portray clinical psychology as a modern **health care profession** that bridges physical and mental health, that is psychosomatic, and that takes a holistic stance; this book does not see clinical psychology as just a branch of mental health care.
- We recognize the importance of biological/physiological assessments because no existing text covers physiological measures beyond offering a mere mention (if that!).
- This book takes an international perspective, trying to describe similarities but also differences between countries and how clinical psychology is practiced in different contexts.
- Recognition is given to how clinical psychology changes as health care systems change, and stresses that training models and practice patterns need to match these changes.
- We try to breathe life into the dynamic nature of change in the therapy process, and how different approaches weave into one another, cross-fertilize, and grow.
- We tried to create excitement by building the text around fairly typical psychologists and the problems they need to solve, stressing how assessment is much more than testing, and how treatment rationales are tailored to individual problems, their histories, and the client's current environment.
- We show that psychoanalysis and psychoanalytic psychotherapies have not stalled and are not disappearing; instead they continue to develop and draw interest.

We know that clinical psychology is offered as a one-semester course in some colleges and universities but also as a full-year course elsewhere. Given that this book is meant to support 1-semester and 2-semester courses alike, it is not likely that instructors can cover all chapters of this book in full detail if their course spans only a single semester. Therefore, we planned the book such that a number of chapters and their corresponding topics could be left out altogether or left as assigned reading to students. This is most likely applicable to Chapter 2 ("how-to-get into graduate school" and psychologists' career paths), and the chapters or sections on subspecialties like Innovative Therapies, Health, Forensic, Child, Psychopharmacology, and the final chapter's "outlook into the future." The sequence of the chapter presentation is mapped onto the sequence of topics covered in Wolfgang Linden's course which is based on over two decades of teaching experience; student feedback had indicated that this order represented a good flow.

We want to alert the reader to certain issues of style and use of terminology that are germane to this book. Throughout the field of mental health, the individuals who receive services are called **patients**, **clients**, or **consumers**. The term "patients" is most likely used in hospitals or other medically dominated environments whereas the term "clients" is typically used in private practice environments. The notion of "patient" embeds the idea that the individual is in pain or distress and that a professional "healer" is involved, whereas "client" also harbors the recognition that there is usually a two-sided contract between the therapist and the client. "Client" also implies more client control over the therapy (or assessment) process than is typically true for patients in hospital environments. Philosophically, we hope that in the long run nobody is seen as a passive recipient of care and that instead we treat patients as partners in care. Given that this book provides numerous examples of clinical practice in widely different environments, we are using the terms "patients" and "clients" interchangeably, and do not want the reader to look for some profound rationale for choosing one term over another at different times.

The term **consumer** is most often used by individuals who work in volunteer mental health organizations or receive services by these organizations. The philosophy of these not-for-profit helping organizations is one of empowerment; they tend to reject the terminology of a more hierarchically organized medical world and its "pathologizing" labels. While we recognize and appreciate the reasoning and suitability of the term "consumer" in this environment, it is not routinely adopted for this textbook.

The world of clinical psychology consists of men and women, in provider and client roles, as well as people of different cultures, skin colors, religions, and sexual orientations. In order to recognize the full representation of both genders in all roles and to avoid the stilted (over-) use of the awkward term "they," we randomly alternate between "she" and "he" when we refer to either patients or psychologists or other individuals. In no case should the reader think that a gender-specific bias is implied if a police officer was referred to as "he" or a nurse was referred to as "she." In fact, we made efforts to occasionally use gender labels that go against such stereotypes.

When clinical psychologists enter the world of health care, they enter a world that is strongly dominated by two health-care professions, namely nurses and physicians. In fact, many people portray the health-care system as consisting of "doctors and nurses," and unfortunately this is equally prevalent in the media who use this descriptor ad nauseam. We want to encourage all clinical psychologists to actively contribute to raising awareness in the general public that there are many different health-care professions. In the university where we teach, there are no less than 11(!!) different professions being trained to become health-care professionals. True, there are more nurses and physicians in the health-care system than other health professions, but that simply means that these other health-care professionals need to make more noise to raise their individual visibility and market themselves. Along these lines we strongly discourage clinical psychologists from participating in the confusing and self-handicapping habit of referring to physicians as "doctors." For hazy reasons of tradition, medical professionals in North America are often referred to as "doctors" although the roots of the word "doctor" have no connection with medicine whatsoever. "Doctor" stems from the Latin verb "docere" which means to teach. Hence, a "doctor" is a teacher or scholar and, in fact, universities have a thousand-year-old tradition of awarding the title Dr. to the most extensively trained scholar. Interestingly, a British-trained physician is awarded a Bachelor of Medicine degree (MB) and not a doctorate title. Also, the title confusion does not exist in other languages such that Spanish-speaking people have a "Medico," the French their "Medicin," and the Germans their "Arzt." In order to take the place that psychologists deserve in the health-care system, we encourage doctoral level trained psychologists to actively use their hard-earned Dr. title and to avoid insidiously eviscerating the power of their own profession by referring to physicians as "doctors."

Writing an undergraduate textbook is a rather gargantuan undertaking that takes committed authors who put much of their lives on hold "until the textbook is done"; they need families that support them, colleagues who suggest, criticize, and occasionally praise, and an editor who fully stands behind them.

On our home turf, there were the diligent and hard-working editorial assistants Alena Talbot Ellis, PhD (who had actually taken Wolfgang Linden's course two years before working on the book), Roanne Millman, BA, and the tireless Victoria Bae, BA, Jacqueline Hewitt, BA, Melanie J. Phillips, MD, Heather Roxborough, MA, and Christopher Siu, BA, who read sections of the book and provided feedback. Friends and colleagues graciously read and commented on some chapters and we thank Charlotte Johnston, PhD, and Roy O'Shaughnessy,

MD, for their critical reading of our material on child clinical psychology and psychopharmacology, respectively. As well, many conversations with colleagues and students over the years have contributed ideas, critiques, and opposing points of view that have influenced the ideas presented in this work. The first major group to thank are the 1,000s of students who have taken Wolfgang Linden's and Paul Hewitt's Clinical Psychology courses over the years and who participated in, or triggered, lively in-class discussions on a myriad of topics. We thank them for their willingness to keep us on our toes but whose curiosity also kept us excited about our field. We greatly appreciate this, and especially thank Samuel Mikail, Gordon Flett, Simon Sherry, Dayna Sherry, Brandy McGee, Carol Flynn, and Lindsey Thomas who through many years of discussion helped shape how we think about the field and how the course is taught. We are greatly in debt to the staff at Taylor & Francis who were exceedingly professional and personable in preparing this second edition with us. We especially enjoyed working with Georgette Enriquez, who as our editor saw the potential of a second edition, and who went out of her way to assure that we had extensive and valuable anonymous reviewer feedback. Her steady support and enthusiasm for this project was a key in keeping us motivated and on track. Brian Eschrich assured further continuity in the editorial office and in correspondence and kept a firm grip on handling permissions and assuring completion of material. Lastly, we were impressed by Holly Smithson for her smooth handling of the editing process and the printing preparations.

Textbook authors also have the good fortune to receive input from (at least initially anonymous) colleagues who provide reviews and feedback through the publisher; their job is not to bolster the egos of the authors with flattering feedback but to take critical stances and comment on all aspects of the product, on style, appeal, comprehensiveness, depth, and so forth. We are profoundly grateful for this critical feedback that gave us a chance to make changes that we hope will maximize the attractiveness of the book for those colleagues who consider textbook adoption. Where things were done right we owe to all the individuals above; where things got messed up, it was our own doing. We truly welcome your feedback as readers; feel free to write to us, or comment on needed improvements for future editions.

1 Being a Clinical Psychologist

Chapter Objectives

The authors of this textbook strongly identify with the profession and the science of clinical psychology and have been ardent proponents and defenders of the idea that as a profession we are distinct. One objective of this first chapter is therefore to circumscribe this unique profession, make it come alive, and get you as excited as we are about clinical psychology even after decades of practice. The learning objectives for this chapter are:

- An appreciation of diverse types of problems that clinical psychologists face, the actual work being done, and the expertise needed to do this work competently.
- An understanding of the training that is involved in developing the identity and skills of a clinical psychologist.
- An appreciation for the blend of science, skill, intuition, and sometimes difficult ethical challenges that shape our professional lives.

Describing the Profession and Its History

Clinical psychologists see clients for formal assessments, conduct psychotherapy, do research, consult and educate. The claim for a "distinctness" of our profession, however, does take some explaining. Specialty areas within psychology are defined by certain subsets of questions or fields of inquiry. Developmental psychology, for example, is interested in growth and change, and biological psychology in the relationship of biology, physiology, and behavior. Of course, these two domains also inform other research domains and areas of practical application. Clinical psychology, on the other hand, denotes a profession that creates and applies knowledge from many subspecialties within psychology and uses these to solve everyday problems across all aspects of health care.

While the paragraph above describes what clinical psychologists do, it does not inform the reader how clinical psychologists think. Scientific training affects the view of a psychologist's own profession and the world at large and also explains the habits and values of clinical psychologists. Three such overarching principles were first described by Galileo (yes, that Galileo), and training in these creates an enduring mindset that permeates our approaches to research and practice. Machado and Silva (2007) describe them as:

1. Observation/experimentation, which essentially reflects the activities, such as methodology, that are used to generate theories and test hypotheses;

2. Quantification/mathematization, which reflects the use of statistical procedures and mathematics to obtain and test data to determine relationships;
3. Theoretical/conceptual analysis, which reflects the clear explication and detailed specification of concepts, constructs, and ideas that derive from or are the focus of research.

All three of these components are important to truly understanding the nature of relationships among psychological constructs; however, Machado and Silva (2007) argue that only the first two tend to be used in psychology research or taught in psychology training programs. For example, although there are courses and emphases in the field on methodological and statistical issues, the issues germane to conceptual analysis tend to be ignored (also see Machado, Lourenco, & Silva, 2000). Although you, as a student of psychology, know, already, a great deal about methodology and statistics from courses you have taken and even from sections of this book, you have likely not been taught about the importance or conduct of conceptual analysis. This means that the clarity and specification of concepts within the field is wanting, which creates incredible confusion. One of the better examples of this is the

IMAGE 1.1 Psychologists on a Date

use of the term "stress," which the literature refers to as nonspecific responses to events, the events themselves, or negative responses to events. Both authors of this text have experienced the problems with the lack of focus on conceptual analysis in their own respective research areas of perfectionism (e.g., Hewitt et al., 2003, 2008) and stress management (Ong, Linden, & Young, 2004). It is hoped that emphases on clear explications of theoretical concepts will be incorporated in both the training and the research in the field and it is one of the major objectives of this textbook to teach **concept clarity**.

Given the scientific training clinical psychologists actively research the questions they deal with in clinical practice, and vice versa; they use their clinical experience to feed new insights and ideas back to researchers. The most frequently used term to describe this two-way flow of ideas and actions is "**Scientist-Practitioner.**" Clinical psychology also can and needs to be defined by how it is different from related disciplines like **Psychiatry** and **Social Work** or **Counseling Psychology** (see Box 1.1) that describes the difference between clinical psychologist, psychiatrist, and social worker.

BOX 1.1 WHAT IS A CLINICAL PSYCHOLOGIST?

Brace yourself. If you are a clinical psychologist, or graduate or even undergraduate student in Psychology, you are prone to be asked at family gatherings or other social events what the difference is between a psychiatrist and a psychologist. Aside from colloquially referring to both as "headshrinkers," and to get that pesky questioner out of your hair, here are some standard definitions that you can supply:

A **Psychologist** is a scientist and/or clinician who studied psychology—the systematic investigation of the human mind, including behavior and cognition. Psychologists are usually categorized by their area of specialty. The most well recognized subgroup in the community is that of the "clinical psychologist," who provides health care, conducts assessments, and provides psychological therapy.

In North America, the typical **Clinical Psychologist** holds a Doctor of Psychology (PsyD) degree if she was trained in a professional school, or a Doctor of Philosophy (PhD) if she was trained in a university-based psychology department. It typically takes 6–7 years above and beyond a Bachelor's degree to become a clinical psychologist. What makes clinical psychologists stand apart from other mental health experts is the balance in their training requiring expertise in both science and practice (see Linden, Moseley, & Erskine, 2005; Linden, 2015 for a review). In much of Europe and Australia, clinical training is offered at the level of Master's degrees and may require additional supervised training before graduates can become independent practitioners and/or are allowed to do third-party billing. The trend in North America is to move toward doctoral level training as a minimal standard although many long-term practitioners hold only a Master's degree and there are still new MA and MSc psychologists getting licensed. When it comes to practice differences, Master's level providers are less likely to work in hospitals, are less often involved in the care of patients with psychosis, and conduct fewer assessments (Hunsley, Ronson, & Cohen, 2013).

Counseling Psychologists are in many ways similar to clinical psychologists but are more likely to become service providers at the Master's degree level (implying a total of 2–3 years of graduate training), have less training and expertise in formal psychodiagnostic assessments, and are less likely to work with populations that have psychoses or severe personality disorders.

Psychiatrists are physicians (and in North America usually doctors of medicine [MD]), who are certified in treating mental illness

using a largely biologically based approach to mental disorders. Psychiatrists first complete regular medical school and then acquire specialty training through a 4-year residency during which they may also go through training to conduct psychotherapy. But it is their medical, biology-based training that allows them to prescribe medication and that differentiates them from other mental health professionals. In North America, it typically takes 8–9 years above and beyond a Bachelor's degree to become a licensed psychiatrist.

The main tasks of **Professional Social Workers** are case management (linking clients with agencies and programs that will meet their financial and psychosocial needs), medical social work, counseling (psychotherapy), human services management, social welfare policy analysis, community organizing, advocacy, teaching (in schools of social work), and social science research. Some social workers, usually those with a graduate degree (MSW), also provide one-on-one clinical services, often in the area of child and family. The training background of social workers who function as psychotherapists can be quite heterogeneous.

The description of the different health professions does show existing overlap in areas of work but also draws boundaries between the different professions. Another way of highlighting these differences is to look at the total hours of training and clinical exposure various health professions have obtained. Murdoch, Gregory, and Eggleton (2015) have systematically compiled and compared the curricular and student training experiences of the professions described above and reveal the high level of preparedness for assessment and therapy that is imbued in doctoral level clinical and counseling psychologists.

Without going into excessive historical detail, the student of clinical psychology should be aware that the field really began to exist as a distinct specialty only after World War II. At this time, clinical psychologists made concerted efforts to define how the topic should be taught and what knowledge practitioners should have. Consistent with the scientist-practitioner model, it was decided that the knowledge base of clinical psychology was so thin and underdeveloped that all students were to be trained in the skills needed to continue building knowledge while also practicing and applying it. This decision was made at the so-called Boulder (Colorado) Conference in 1949 and the scientist-practitioner model is therefore also sometimes called the Boulder model. Today, clinical psychology is typically taught via well-structured, **accredited training programs**; these programs provide its graduates with an identity, and clinical psychologists now have an-established place in health care (Linden et al., 2005).

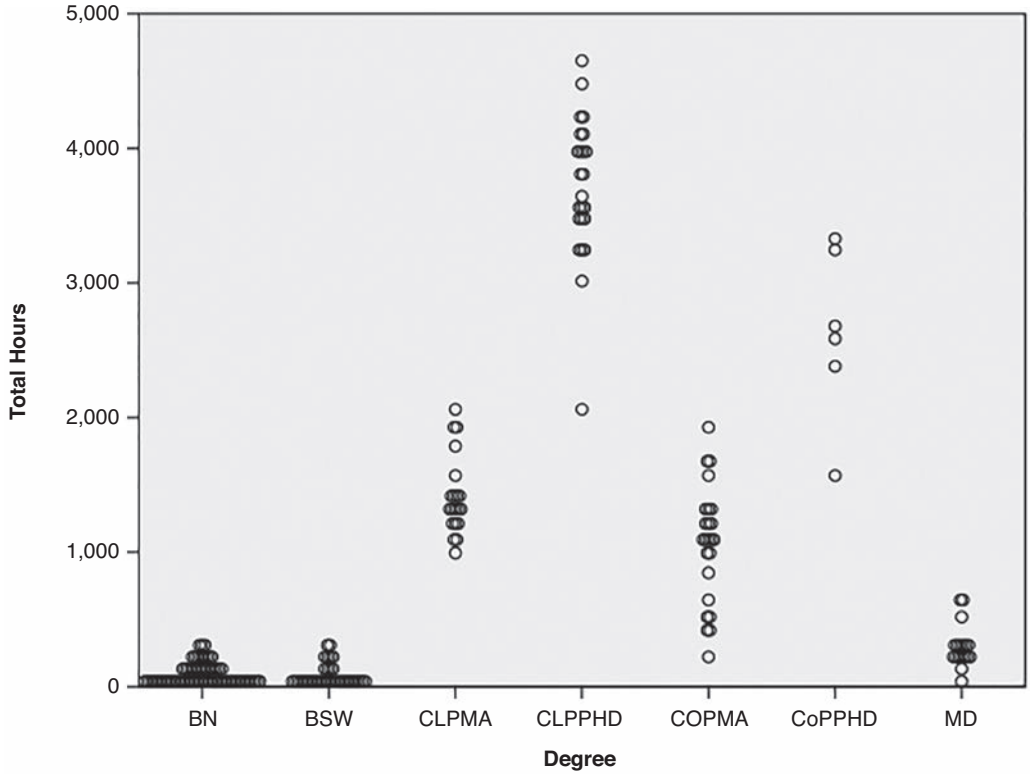
Rather than exposing the reader with more detailed history of the field, we will start by describing three currently practicing kinds of clinical psychologists and one clinical psychology graduate student. Typical work days and challenges will be illustrated.

The detailed descriptions of a graduate student's and the three psychologists' daily lives are amalgamations of the work that psychologists known to us really do and also covers tasks that we ourselves are involved in. None of the descriptions of specific work environments are to reflect critically upon an existing facility; they should be treated as fictional.

The clinical graduate student we describe is in the later portion of his academic training. The three clinical psychologists we introduce work in a hospital setting, in full-time private practice, and as a university professor, respectively.

FIGURE 1.1 Hours of Training in Mental Health for Various Health Professionals

From Murdoch, D. D., Gregory, A., & Eggleton, J. M. (2015) Why Psychology? An investigation of the training in psychological literacy in Nursing, Medicine, Social Work, Counselling Psychology and Clinical Psychology. *Canadian Psychology*, *56*, 136–146.



Note: BN = undergraduate Nursing; BSW = undergraduate Social Work Programs; CLPMA = clinical psychological Master's level program; CLPPHD = clinical psychology doctoral level programs; COPMA = counselling psychology Master's level programs; CoPPHD = counselling psychology doctoral level programs; MD = undergraduate medicine.

The Challenges and Responsibilities of Four Different Psychologists

A Clinical Psychology Student

Description of a Typical Day

Vincent S, is a 4th-year clinical psychology graduate student who entered a clinical psychology graduate program because of his strong desire to help others, a marked curiosity in understanding the way people function, and a desire to do both clinical work and research. A reasonably typical day in his life involves a busy schedule of training activities that involve both research and clinical work (Box 1.2).

BOX 1.2 A TYPICAL DAY OF GRADUATE STUDENT VINCENT S

Time	Activity
9 a.m.–12 p.m.	From 9 a.m. to noon, he participates in a 3-hour advanced seminar on psychopathology
12 p.m.	Meets his clinical supervisor to discuss the last therapy session
1 p.m.–4 p.m.	Eats a quick lunch and then researches articles pertaining to his dissertation topic, making notes
4 p.m.	Meeting of the lab team; an advanced graduate student gives a dry-run of her presentation for her upcoming thesis defense. The team then deals with logistical issues for setting up a study protocol for a new study in the laboratory
5 p.m.	Work-out in the university gym
6 p.m.	Dinner break
7 p.m.–9 p.m.	Vincent sees patients in the Psychology Clinic

The 3-hour seminar on psychopathology (i.e., abnormal behavior) involves a detailed analysis and discussion of models and treatment options for somatoform disorders. Based on assigned readings and on a critical analysis of those readings it was expected that Vincent, along with his other five classmates, evaluates the support, or lack of support, for various theoretical models. Following the clinical seminar, Vincent was scheduled to have supervision with his clinical supervisor who was overseeing Vincent's treatment of a patient who exhibited both marked depression and anxiety in response to upcoming applications to several very prestigious law schools. The issues of a strong desire for achievement and real concern over one's ability to perform at a high level were also concerns that Vincent, personally, had experienced and, at times, continues to experience. Vincent believed, correctly, that his own personal concerns with the same issues might interfere with the treatment he was providing or, at least, might cloud his judgment somewhat. The clinical supervision involved first discussing Vincent's personal issues over performance as well as a discussion of how his own views/feelings might influence the treatment process in order to help Vincent become better at the treatment. Following supervision, Vincent felt better able to deal with the patient's issues next session. Next, Vincent spent several hours reading research articles pertaining to his dissertation topic. The dissertation is to be a major original research project designed to have the student conduct an independent (although supervised by a faculty member), and relatively large-scale, research project that produces new knowledge within a particular field in psychology. Vincent was at the stage of formulating a research question within the area he had chosen, namely personality factors and their link to suicide behavior, and was working on a review of the relevant literature to determine areas that required further investigation. He would be meeting with his research supervisor in several days and go over a written document that detailed the rationale for several potential research questions.

Following a break for dinner, Vincent was slated to work in the departmental teaching clinic, seeing patients. The Psychology Clinic is kept open one evening every week to

accommodate clients with full-time jobs. The first appointment was with the client described earlier and, as a result of reviewing his notes and the supervision he received earlier, Vincent felt prepared. The second appointment was a couple who were having marital difficulties and this was a first session. Although Vincent had not previously seen any couples for treatment, he was simultaneously anxious and keen to see them. He had read extensively about marital therapy, taken a marital/family treatment clinical course last year, and had met with his clinical supervisor regarding this particular couple and discussed approaches for dealing with the first session. At the conclusion of the last treatment session, he completed case notes and made preparations for the next day.

Specific Concerns

- *How does Vincent critique, analyze, and synthesize both theoretical models and clinical research pertaining to those models and discuss these in a coherent fashion? (Chapters relevant: 4–13)*
- *How does Vincent suspect that his personal issues may be influencing his treatment of a patient and how does he know what to do about it? (Chapters relevant: 4, 10)*
- *Where does Vincent look for relevant literature for his dissertation and produce a clinically relevant research project? (Chapters relevant: 3–9)*
- *How does Vincent know that he has commenced marital therapy in an ethically appropriate fashion that will maximize helping the couple? (Chapters relevant: 4, 10–12)*

Clinical Psychologist A—Working in a General Hospital Setting

Dr. Marisa A is trained in clinical psychology with a subspecialty in **Behavioral Medicine**. She is employed full-time by a large general hospital and spends her time doing about equal portions of (a) direct service provision (providing individual and group treatments) for distressed patients who have been diagnosed with cancer or heart disease, and (b) consultation with various in-house services that might need her help on an ad hoc basis (e.g., the eating disorders program, or the organ transplant team). See Box 1.3.

BOX 1.3 A TYPICAL DAY OF HOSPITAL PSYCHOLOGIST MARISA A

Time	Activity
9 a.m.	Visits two patients on the surgical recovery ward who had a heart transplant and coronary bypass surgery, respectively. Discusses plans for their release and the need to make lifestyle changes
10 a.m.	Conducts an assessment of the suitability of a patient with alcohol problems for a possible liver transplant
11 a.m.	Meets with the multidisciplinary transplant team to determine who of three new referrals is suitable to go on to the wait-list for an organ transplant
12 p.m.	Attends Grand Rounds to learn about the latest in the sequelae of head injuries

1 p.m.	Lunch with a colleague who plans to set up a specialty clinic for borderline personality disorder and needs informal feedback on how to go about it
2 p.m.	Supervision session with three interns who go through various rotations while on internship in her hospital
3 p.m.	Catches up on e-mails and prepares for the 4 p.m. therapy group she leads
4 p.m.	Runs a 90-minute psycho-educational group for patients in curative cancer treatment
5:30 p.m.	Writes up progress notes from the psycho-educational group
6 p.m.	Goes home

She has completed two years of specialty training after she had completed her PhD in this type of hospital setting and has had multiple interesting job offers given the breadth of her skills. She has been at this hospital for 15 years and feels respected by her medical and nursing colleagues.

A particularly exciting and challenging request presented to Dr. A was to develop a distress-screening program for the cancer clinic. The cancer clinic had been told by an accreditation committee that it failed to have systematic procedures for identifying cancer patients in greatest need of professional psychological support. Although a family support and counseling service was available to patients, there was the suspicion that only those patients who were particularly vocal in asking for help ended up receiving it. There was a good chance that uneducated and unassertive patients were left out.

Dr. Marisa A decided to develop a **distress-screening** tool that was brief, easy to read even for patients with poor reading skills, and that would have the ability to quickly and precisely identify the patients most in need.

Specific Concerns

Dr. A made a list of questions she knows she had to tackle:

- *What psychological characteristics will be the most important ones to measure?*
- *Even if distress was readily measurable with this new tool, how will she know how much distress or anxiety is too much and require professional support?*
- *Will there be enough resources in the hospital or the community to handle the problems that screening will identify?*
- *Should screening actually go ahead if one knows ahead of time that identified needs cannot be met?*
- *How does one actually develop a test, write test items, and evaluate their usefulness? How can she establish that the test is measuring what it is supposed to and that it does so reliably?*
- *Once the test is developed, will the clinic staff readily accept and use it? How can it be applied most efficiently?*

The kind of information that Dr. A will need to meet these challenges covers issues of ethics (see Chapter 4), an understanding of the sometimes complicated administration and

internal politics of medical clinics and the health care system in general (see Chapters 17 and 19), as well as the more theoretical and practical questions of test development and test application itself (see Chapters 3, and 6–8).

Clinical Psychologist B—Working in a Private Practice Setting

Description of Typical Day

Dr. Ramin B is a clinical psychologist in general private practice in a small community; his work entails mainly clinical assessments and treatment of adults with a variety of psychological problems, although he also sees children and adolescents for assessment and treatment of specific disorders including depression and anxiety. See Box 1.4.

BOX 1.4 A TYPICAL DAY OF PSYCHOLOGIST IN PRIVATE PRACTICE RAMIN B

Time	Activity
9 a.m.	Reads a medical chart to prepare for an assessment to begin at 10 am
10 a.m.–12 p.m.	Conducts a formal clinical assessment of a depressed client currently on medical leave. This involves a structured interview and standardized personality tests to help prepare a report to the client's insurance company
12 p.m.	Scores the tests and dictates case notes while the memory is fresh
1 p.m.	Lunch and returning phone calls
2 p.m.	Has a lengthy conference call with a community care team regarding a care plan for an elderly, widowed patient with dementia
3 p.m.	Interpersonal psychotherapy for depression
4 p.m.	Psychotherapy with a client who presents with perfectionism and obsessive-compulsive cleaning habits
5 p.m.	Marital therapy with a couple considering divorce
6 p.m.	Writing up case notes and returning phone calls
6:30 +	Going home

Dr. B has, what he would term, an eclectic orientation, meaning that he pulls from a variety of clinical perspectives in assessing and treating individuals. He also endorses that his main theoretical perspective would be consistent with a psychodynamic perspective. He has been trained in both psychodynamic and cognitive-behavioral techniques and carefully chooses the one approach most suitable to the client's presenting problem.

A typical day might begin with an assessment of an individual who reported marked dissatisfaction with life including intimate relationships, work, and family, described long-standing dysthymia and a recent significant depressive episode. Dr. B was evaluating