psychopathology in adulthood, including postwar symptoms (years later referred to as posttraumatic stress disorder, or PTSD) and acute psychosis. Revisions of this manual have appeared periodically, the most recent one in 2000 (*DSM-IV-TR*). DSM-V is scheduled to be published in 2013. In addition to this diagnostic system's influence on the content of self-report inventories (new inventories were designed to measure the *DSM* mental disorders), it spurred the growth of another line of assessment tools—the *structured diagnostic interviews*. These interviews consist of a standard list of questions that are keyed to the diagnostic criteria for various disorders from the *DSM*. Clinicians (or researchers) who need to formulate a *DSM* diagnosis for a patient (or research participant) can use these interviews; it is no longer necessary to administer a psychological test and then infer a patient's diagnostic status from his or her test scores.

Interest in *neuropsychological assessment* has grown tremendously as well. Neuropsychological assessment is used to evaluate relative strengths and deficits of patients based on empirically established brain–behavior (test responses) relationships. Several tests and measures were introduced to detect impaired neurological functioning. In 1947, Halstead introduced an entire test battery to aid in the diagnosis of neuropsychological problems. Contemporary neuropsychological assessment typically involves one of two approaches. Some use a uniform group, or battery, of tests for all patients. Others use a small subset of tests initially and then, based on the results of these initial tests, use additional tests to resolve and answer the referral questions. Some of the more popular neuropsychological test batteries include the Halstead-Reitan (Reitan, 1969) and the Luria-Nebraska Neuropsychological Battery (Golden, Purisch, & Hammeke, 1985). The field of neuropsychology is becoming increasingly sophisticated. Many neuropsychological tests are now computer administered, more attention is being directed to identifying neuropsychological correlates of mental disorder, brain imaging resources are now available to neuropsychologists to both validate and supplement information garnered from neuropsychological tests, and test results are integral components of rehabilitation planning.

Finally, the rise and popularity of managed health care in the 1990s had an impact on psychological assessment. Although we will discuss this trend in more detail in Chapter 3, it is worth highlighting here. Managed health care (including mental or behavioral health) developed in response to the rapidly increasing cost of health care. Third-party insurers (e.g., large companies) were attracted to managed health care because it controlled and reduced costs. Managed health care requires those who provide services to be more accountable and more efficient in service delivery. Clinical psychologists who are providers for various managed health care plans have become increasingly interested in using reliable and valid psychological measures or tests that (a) aid in treatment planning by identifying and accurately assessing problematic symptoms, (b) are sensitive to any changes or improvements in client functioning as a result of treatment, and (c) are relatively brief.

A number of these assessment highlights are summarized in the timeline Significant Events in Assessment.

## INTERVENTIONS

### The Beginnings (1850–1899)

Emil Kraepelin's focus was on the classification of psychoses. However, others were investigating new treatments for "neurotic" patients, such as suggestion and hypnosis. Specifically, Jean Charcot gained a widespread reputation for his investigations of patients with hysteria—patients with "physical symptoms" (e.g., blindness, paralysis) that did not seem to have an identifiable physical cause (Figure 2-2). He was a master of the dramatic

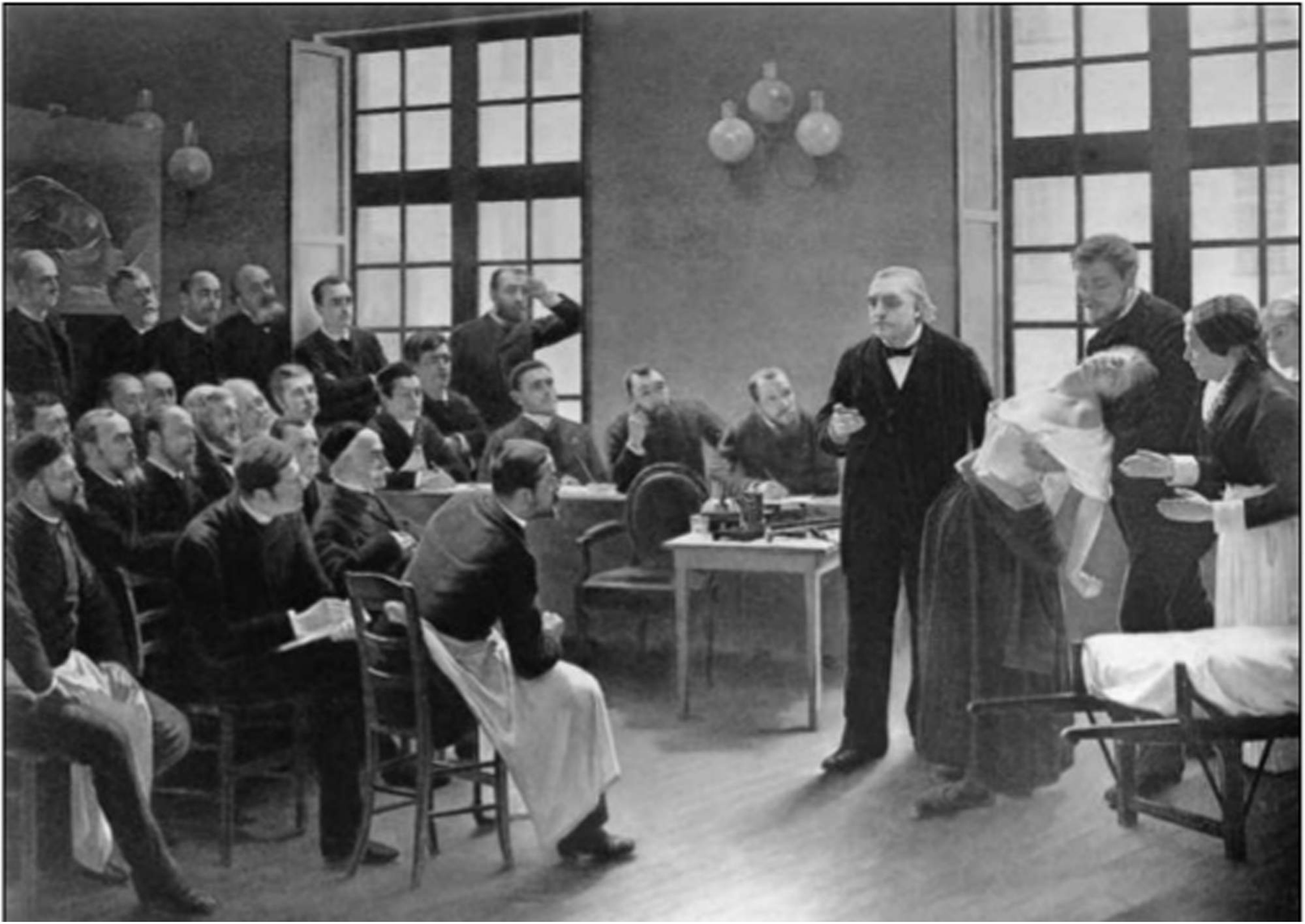


**FIGURE 2-3** Clifford Beers wrote *A Mind That Found Itself*, a chronicle of his experiences while hospitalized as a mental patient. His efforts were instrumental in launching the mental hygiene movement.

manic-depressive symptoms, he was released. However, this release did not weaken his resolve to write a book exposing the abuses in the hospital care of the mentally ill. He very much wanted to generate a public movement to rectify those abuses. In 1908, *A Mind That Found Itself* was published, and the mental hygiene movement in America was launched (Figure 2-3).

In 1900, shortly before Beers entered the hospital, Freud published *The Interpretation of Dreams*. With this event, the psychoanalytic movement was in full swing. Concepts such as the unconscious, the Oedipus complex, and the ego became part of the mainstream of psychological language, and sexuality became a focus within the psychological realm. Freud's ideas were by no means an overnight success. Recognition was slow in coming, but converts did begin to beat a path to his door. Alfred Adler, Carl Jung, and others began to take notice. Freud published other books, and the list of converts grew still longer, including A. A. Brill, Paul Federn, Otto Rank, Ernest Jones, Wilhelm Stekel, Sandor Ferenczi, and others.

Earlier in this chapter, we noted Lightner Witmer's establishment of the first psychological clinic. Also important was William Healy's establishment of a child guidance clinic in Chicago in 1909. This clinic used a team approach involving psychiatrists, social workers, and psychologists. They directed their efforts toward what would now be labeled juvenile offenders rather than toward the learning problems of children that had earlier attracted Witmer's attention. Healy's approach was greatly influenced by Freudian concepts and methods. Such an approach ultimately had the effect of shifting clinical psychology's work with children in the dynamic direction of Freud rather than into an educational framework.

In 1905, Joseph Pratt, an internist, and Elwood Worcester, a psychologist, began to use a method of supportive discussion among hospitalized mental patients. This was the forerunner of a variety of group therapy methods that gained prominence in the 1920s and 1930s.

## Between the Wars (1920–1939)

The psychoanalysis of the early 20th century was largely devoted to the treatment of adults and was practiced almost exclusively by analysts whose basic training was in medicine. Freud, however, argued that psychoanalysts did not need medical training. Despite Freud's protestations (Freud, 1926/1959), the medical profession claimed exclusive rights to psychoanalytic therapy and in so doing made the subsequent entry of psychologists into the therapy enterprise quite difficult.

The eventual entry of psychologists into therapeutic activities was a natural outgrowth of their early work with children in various *guidance clinics*. At first, that work was largely confined to the evaluation of children's intellectual abilities, and this, of course, involved consultations with parents and

teachers. However, it is hard to separate intellectual functioning and school success from the larger psychological aspects of behavior. As a result, it was only natural that psychologists should begin to offer advice and make recommendations to parents and teachers about managing children's behavior.

As psychologists looked for psychological principles to aid in their efforts, the work of both Freud and Alfred Adler came to their attention. In particular, they were impressed by Adler's work, which had a more commonsense ring than Freud's. Moreover, Freud's emphasis seemed to lie with adults and with the sexual antecedents of their problems, whereas Adler's deemphasis of the role of sexuality, and his concomitant emphasis on the structure of family relationships, seemed much more congenial to American mental health professionals in the field. By the early 1930s, Adler's (1930) ideas were firmly ensconced in those American clinics that dealt with children's problems.

A second trend that influenced early work with children—*play therapy*—was more directly derived from traditional Freudian principles. Play therapy is essentially a technique that relies on the curative powers of the release of anxiety or hostility through expressive play. In 1928, Anna Freud, the distinguished daughter of Sigmund Freud, described a method of play therapy derived from psychoanalytic principles.

Group therapy also began to attract attention. By the early 1930s, the works of both J. L. Moreno and S. R. Slavson were having an impact. Another precursor of things to come was the technique of "passive therapy" described by Frederick Allen (1934). In this approach, one can see some of the first stirrings of what would become client-centered therapy. But there were other straws in the wind too. In 1920, John Watson described the famous case of Albert and the white rat, in which a young boy was conditioned to develop a neurotic-like fear of white, furry objects (Watson & Rayner, 1920). A few years later, Mary Cover Jones (1924) showed how such fears could be removed through conditioning. Still later, J. Levy (1938) described "relationship therapy." These latter three events marked the beginnings of *behavior therapy*, a very popular and influential group of therapeutic methods used today.

## World War II and Beyond (1940–Present)

World War II not only required enormous numbers of men but also contributed to the emotional difficulties that many of them developed. The military physicians and psychiatrists were too few in number to cope with the epidemic of these problems. As a result, psychologists began to fill the mental health breach. At first, the role of psychologists was ancillary and often mainly involved group psychotherapy. But increasingly, they began to provide individual psychotherapy, performing well in both the short-term goal of returning men to combat and in the longer-term goal of rehabilitation. Psychologists' successful performance of these activities, along with their already demonstrated research and testing skills, produced a gradually increasing acceptance of psychologists as mental health professionals.

This wartime experience whetted the appetites of psychologists for greater responsibility in the mental health field. It is uncertain whether this increasing focus on psychotherapy stemmed from a desire to gain greater professional responsibility, an awareness that they possessed the skills to perform mental health tasks, an embryonic disenchantment with the ultimate utility of diagnostic work, or some combination of the three. However, the stage had been set.

An additional contributing factor to this chain of events was an outgrowth of the turmoil in Europe in the 1930s. The pressures of Nazi tyranny forced many European psychiatrists and psychologists to leave their homelands, and many of them ultimately settled in the United States. Through professional meetings, lectures, and other gatherings, the ideas of the Freudian movement generated excitement and also gained increasing credence in psychology. Partly as a result, clinical psychologists began to temporarily reduce their emphasis on the assessment of intelligence, ability testing, and the measurement of cognitive dysfunction and became more interested in personality development and its description.

As intelligence testing receded in importance, psychotherapy and personality theory began to move into the foreground. A large part of the activity in these