2 EVOLUTION OF CLINICAL PSYCHOLOGY

LEARNING OBJECTIVES

2.1 Summarize major contributions of early pioneers, such as William Tuke and Eli Todd, to mental health care from the 1700s to the late 1800s.

2.2 Describe Lightner Witmer's key contributions to the field of clinical psychology.

2.3 Describe examples of racist or prejudiced acts committed throughout the history of clinical psychology.

2.4 Recount the development of assessment in clinical psychology, including diagnostic systems for mental illness, assessment of intelligence, and assessment of personality.

2.5 Recount the development of psychotherapy over the history of clinical psychology.

2.6 Discuss the development of the profession of clinical psychology in the United States.

ORIGINS OF THE FIELD AND EARLY PIONEERS

Psychology, as we know, has a long, rich history, with roots winding back to some of the great thinkers of prior millennia, such as Socrates, Plato, Aristotle, Ptahhotep, and Confucius (Benjamin, 2007; Ehrenwald, 1991). The history of *clinical* psychology is certainly rich as well, but it's also shorter than some might expect. Of course, in recent decades, the clinical specialization has enjoyed great popularity and notoriety among psychology professionals and the general public; in fact, today, when many people hear of a "psychologist," they immediately think of a "clinical psychologist" practicing psychotherapy or assessment. This assumption regarding psychology was inaccurate until at least the early 1900s. The discipline of clinical psychology simply didn't exist until around the turn of the 20th century, and it didn't rise to prominence for decades after that.

Even before "clinical psychology" per se had been created, numerous influential individuals in various parts of the world were working to make positive changes in the lives of people with mental illness. Collectively, their accomplishments created a climate from which clinical psychology could emerge. Specifically, in the 1700s and 1800s, people with mental illness were

generally viewed and treated much more unfavorably than they are today. In many parts of the world, including much of the western hemisphere, they were understood to be possessed by evil spirits. Or they were seen as deserving of their symptoms as a consequence of some reprehensible action or characteristic. They were frequently shunned by society and were "treated" in institutions that resembled prisons more than they did hospitals (Reisman, 1991).

During this time, numerous individuals of various professional backgrounds from Europe and North America assumed the challenge of improving the way people with psychological problems were regarded and treated. Through their efforts, their countries and others around the world eventually adopted a new, more humane, approach to people with mental illness, foretelling the emergence of clinical psychology as a formal discipline. The accomplishments of several of these pioneers are described below.

William Tuke (1732–1822)

In his homeland of England, **William Tuke** heard about the deplorable conditions in which people with mental illness lived. He visited asylums to get a firsthand look, and he was appalled by what he saw. Tuke devoted much of his life to improving these conditions. He raised funds to open the **York Retreat,** a residential treatment center where people with mental illness would always be cared for with kindness, dignity, and decency. The simple act of labeling his facility a "retreat" suggests a fundamentally different approach to people with mental illness compared with the dominant approach at the time. Patients received good food, frequent exercise, and friendly interactions with staff. The York Retreat became an example of humane treatment, and soon similar institutions opened throughout Europe and the United States. Long after his death, Tuke's family members continued to be involved in the York Retreat and the movement to improve treatment of mentally ill individuals (Reisman, 1991).

Philippe Pinel (1745–1826)

What William Tuke was to England, **Philippe Pinel** was to France—a liberator of people with mental illness. Like Tuke, Pinel worked successfully to move people with mental illness out of dungeons in Paris, where they were held as inmates rather than treated as patients (Cautin, 2011; Charland, 2015; Ehrenwald, 1991). He went to great lengths to convince his contemporaries and those in positions of power in France that people with mental illness were not possessed by devils and that they deserved compassion and hope rather than maltreatment and scorn. He created new institutions in which patients were not kept in chains or beaten but were instead given healthy food and benevolent treatment. Particularly noteworthy, Pinel advocated for the staff to include in their treatment of each patient a written case history, ongoing treatment notes, and an illness classification of some kind—components of care that suggested he was genuinely interested in improving these individuals' lives rather than locking them away (Reisman, 1991).

From Pinel's *Treatise on Insanity* in 1806, we get a sense of his goal of empathy rather than cruelty for people with mental illness: "To rule [people with mental illness] with a rod of iron, as if to shorten the term of an existence considered miserable, is a system of superintendence, more distinguished for its convenience than for its humanity or success" (as quoted in Ehrenwald, 1991, p. 217).

As Frances (2013a) describes Pinel, "our field couldn't possibly have a better father and role model . . . Pinel liked his patients as people and treated them as if they were simply human. When given the choice of joining Napoleon as a personal physician or staying with his patients, he turned down Napoleon" (p. 57).

In Europe in the late 18th and early 19th centuries, society's views toward people with mental illness were undergoing significant change and "the voices of Pinel and Tuke were part of a growing chorus that sang of individual rights and social responsibility" (Reisman, 1991, p. 9).

Eli Todd (1762–1832)

Eli Todd made sure that the chorus of voices for humane treatment of people with mental illness could also be heard on the other side of the Atlantic Ocean. Todd was a physician in Connecticut in 1800, a time when only three states had hospitals for people with mental illness. The burden for treating people with mental illness typically fell on their families, who often hid their mentally ill relatives out of shame and embarrassment. Todd learned about Pinel's efforts in France, and he spread the word among his own medical colleagues in the United States. They supported Todd's ideals both ideologically and financially, such that Todd was able to raise funds to open **The Retreat** in Hartford, Connecticut, in 1824. Todd ensured that patients at The Retreat were always treated in a humane and dignified way. He and his staff emphasized patients' strengths rather than weaknesses, and they allowed patients to have significant input in their own treatment decisions. Similar institutions were soon opened in other U.S. states as leaders elsewhere learned of Todd's successful treatment plan for people with mental illness (Reisman, 1991).

Dorothea Dix (1802–1887)

Despite Eli Todd's efforts, there were simply not enough hospitals in the United States to treat people with mental illness, and as a result, these individuals were too often sent to prisons or jails in an attempt to find any social institution that could house them. In 1841, **Dorothea Dix** was working as a Sunday school teacher in a jail in Boston, where she saw firsthand that many of the inmates were placed there as a result of mental illness or intellectual disability rather than crime. Dix devoted the rest of her life to improving the lives and treatment of people with mental illness. Typically, she would travel to a city, collect data on its treatment of people with mental illness, present her data to local community leaders, and persuade them to treat people with mental illness more humanely and adequately. She repeated this pattern again and again, in city after city, with remarkable success. Her efforts resulted in the establishment of more than 30 state institutions for people with mental illness throughout the United States (and even more in Europe and Asia), providing more decent, compassionate treatment for people with mental illness than they might have otherwise received (Reisman, 1991).

Tuke, Pinel, Todd, and Dix did not create clinical psychology. Their efforts do, however, represent a movement prevalent through much of the Western world in the 1700s and 1800s that promoted the fundamental message that people with mental illness deserve respect, understanding, and help rather than contempt, fear, and punishment. As this message gained power

and acceptance, it created fertile ground in which someone—Lightner Witmer—could plant the seed that would grow into clinical psychology (Cautin, 2011).

LIGHTNER WITMER AND THE CREATION OF CLINICAL PSYCHOLOGY

Lightner Witmer (1867–1956) was born in Philadelphia and earned an undergraduate degree in business at the University of Pennsylvania. He eventually received his doctorate in psychology in 1892 in Germany under Wilhelm Wundt, who many label as the founder of experimental psychology. Witmer also studied under James McKeen Cattell, another pioneer of experimental psychology (Reisman, 1991; Routh, 2015c). At the time Witmer received his doctorate, psychology was essentially an academic discipline, a field of research. It had almost none of the applied functions that characterize the field today, like psychotherapy or assessment. In short, in the late 1800s, psychologists didn't *practice* psychology; they *studied* it (Vasquez & Kelly, 2016).

A major historical shift took place 4 years after Witmer received his doctoral degree when, in 1896, he founded the first psychological clinic at the University of Pennsylvania, where he had returned as a professor (Routh, 1996). Although it may be difficult to imagine from our contemporary perspective of the field, Witmer's clinic was the first time that the science of psychology was systematically and intentionally applied to people's problems. At the 1896 convention of the American Psychological Association, Witmer (1897) spoke to his colleagues and fellow members about his new clinic and encouraged them to open their own—to "throw light upon the problems that confront humanity" (p. 116)—but they were largely unenthusiastic (Reisman, 1991). Decades later, though, clinical settings proliferated. By 1914, there were about 20 psychological clinics in the United States, most of which were modeled on Witmer's clinic (Schultz & Schultz, 2011). By 1935, the number had soared to more than 150, and an issue of Witmer's journal from that year was dedicated to a survey of activities taking place in these clinics, as well as some specific suggestions for the training of clinical psychologists (Brown, 1935).

In his clinic, Witmer and his associates worked with children whose problems arose in school settings and were related to learning or behavior (Benjamin, 2007; Routh, 2015c). The children were referred to the clinic by their schools, parents, physicians, or community authorities (McReynolds, 1997). Witmer (1907) emphasized that clinical psychology could be applied to adults as well as children, or to problems that had nothing to do with school: "Indeed, the clinical method is applicable even to the so-called normal child. . . . Whether the subject be a child or an adult, the examination and treatment may be conducted and their results expressed in the terms of the clinical method" (p. 9).

In addition to establishing his clinic, Witmer also founded the first scholarly journal in the field (entitled *The Psychological Clinic*) in 1907 (Benjamin, 2007). Witmer authored the first article, titled "Clinical Psychology," in the first issue. This article included the first known publication of the term *clinical psychology*, as well as a definition of the term and an explanation of the need for its existence and growth. The article began with a description of Witmer's (1907) innovation: "During the last ten years the laboratory of psychology at the University of Pennsylvania has conducted, under my direction, what I have called a 'psychological clinic'" (p. 1).

We discussed Witmer's original definition of clinical psychology in Chapter 1, but a consideration in this chapter of Witmer's historical significance gives us an opportunity to examine it further. First, it is worth noting that Witmer defined clinical psychology as related to medicine, education, and social work but stated that physicians, teachers, and social workers would not be qualified to practice clinical psychology. Instead, this new field represented a hybrid of these and other influences, requiring a specially trained professional. It is also interesting that Witmer's definition of clinical psychology is basically uninfluenced by Sigmund Freud, whose ideas were prominent at the time, and that psychotherapy, as it would come to be known, was not explicitly discussed at all. Finally, the treatments that Witmer does discuss in his original definition aren't accompanied by any mention of a plan for empirically measuring their effectiveness, which is a bit surprising given Witmer's graduate training as an experimental researcher (Routh, 1996; Witmer, 1907).

So by the late 1800s, the work of Tuke, Pinel, Todd, Dix, and others had set the stage for the birth of clinical psychology. Witmer proudly announced its arrival, and although it would thrive in later years, "clinical psychology in the 1890s was a glimmer, a baby just catching its first breath, drawing its life from the new science of psychology" (Reisman, 1991, p. 44).

RACISM AND PREJUDICE IN THE HISTORY OF CLINICAL PSYCHOLOGY

Before we move on to the evolution of specific components of clinical psychology—assessment, psychotherapy, and the profession itself—it is important to acknowledge the significant extent to which racism and prejudice are interwoven in its history. Racist and prejudiced actions have at times been committed by specific clinical psychologists, and at other times been committed by the institution of clinical psychology itself. Recognizing and condemning these acts, and making concerted efforts to promote more antiracist, inclusive, and equitable approaches, are essential steps for contemporary clinical psychologists.

The loosely chronological list below is an abbreviated sample of the stains on the history of clinical psychology based on racism and prejudice. Some may not have been committed by people with clinical psychology degrees per se (they may have had degrees in other, closely related fields, for example), but all of them involve essential elements of clinical psychology. For a more extensive list, see the sources from which these examples were pulled (American Psychological Association, 2022; Constantine, 2007; Fernando, 2017; Guthrie, 2004; Newnes, 2021; Williams, 2020).

- In 1851, physician Samuel A. Cartwright explained slaves' attempts to free themselves by proposing a new mental disorder category, drapetomania, which he defined as a disease in slaves that prompts them to run away rather than remain submissive to White masters.

- In the 1800s and early 1900s, some prominent figures in psychology (including Francis Galton) aligned themselves with the eugenics movement, which promoted

the idea that society should control reproduction opportunities to increase racially desirable qualities in the next generations. Some of these psychologists created or used intelligence tests that they used to measure fitness to reproduce, and thousands who scored too low were sterilized to prevent them from having children. In the early 1900s, most U.S. states had laws governing these kinds of sterilization practices, often using terms like "feeble-mindedness" or "mental deficiency" (which the psychologists' intelligence tests helped to determine) as justification for sterilization decisions. Those who were sterilized were disproportionately people of color, low socioeconomic status, or disabled.

- G. Stanley Hall, who became the first president of the American Psychological Association in 1892, described people of African, Indigenous, and Chinese heritage as immature races whose development was inferior to that of White people. He promoted "civilizing programs" for Native Americans' supposed need to further develop, and those programs included efforts to strip Native Americans of their culture, language, and spiritual beliefs.

- Lewis Terman, a psychologist, early APA president, and creator of a still-influential IQ test (the Stanford-Binet, as mentioned elsewhere in this chapter), described Black people as dull due to racial inheritance. He also recommended that Black children be educated differently than White children because their intellectual skills were limited to concrete and practical tasks, not the ability to think abstractly.

- In the 1930s, Carl Jung, a once-prominent figure in the psychotherapy field whose theories still retain some followers today, described African people as primitive and inferior, and by contrast described White people as civilized.

- In the 1930s, results of a survey of psychologists showed that 25% of them agreed that the inherent mental ability of Black people was inferior to that of White people. Another 64% said the data were inconclusive, and only 11% said the inherent mental abilities of the two groups was equal.

- When the U.S. Army asked the American Psychological Association (and some specific psychologists) to create intelligence tests to help determine whether prospective soldiers were fit to serve, the tests were quite culturally biased, with references to things, words, and ideas that were much more common knowledge in the lives of White people than in the lives of people of color. Results showed that even when education level was controlled for, Black people consistently scored lower than White people on these tests.

- In the 1960s, Arthur Jensen, an influential professor of psychology at the University of California, made the claim that Black people had lower IQs than White people, and that the difference was due to genetic factors. He also argued that Black people were better at rote learning than abstract thinking. His claims were promoted by racist and neo-Nazi organizations.

- In the 1990s, Harvard psychologist Richard J. Herrnstein coauthored a book about IQ called *The Bell Curve*, which argued that Black people were genetically inferior to White people and Asian people in terms of intelligence.

- In the 2000s, research on microaggressions shows that Black therapy clients often experience microaggressions from White therapists, and that when they do, those microaggressions are likely to undo any benefit of the therapy and leave Black clients in a worse psychological state than when they started.

Thankfully, the field of clinical psychology (and psychology more broadly) have made progress in terms of racism and prejudice, especially in more recent years. For example, in 2021 APA published a formal apology for its role in promoting racism and racial discrimination over the history of psychology, as well as documents describing commitments to work toward the dismantling of systematic racism and promoting health equity (APA, 2022). And the Society of Clinical Psychology (APA Division 12) has a standing Diversity Committee that works toward providing equitable services to traditionally underrepresented groups and shares diversity-related materials on its website (Society of Clinical Psychology, 2002). Significant opportunity remains, however, for clinical psychology to make improvements related to racism and prejudice.

ASSESSMENT

Diagnostic Issues

Categorizing mental illness has been an issue central to clinical psychology since Witmer defined the field. Actually, the debate began long before Witmer entered the picture.

With so many mental disorders tossed around as common terminology today, it can be difficult to imagine a time when such labels didn't exist at all, at least not in any formal sense. In the 1800s in Europe, labeling systems for mental illness began to take shape in a very rudimentary way. Specifically, mental illnesses were often placed in one of two very broad categories: **neurosis** and **psychosis**. Neurotic individuals were thought to suffer from some psychiatric symptoms (including what we would now call anxiety and depression) but to maintain an intact grasp on reality. Psychotic individuals, on the other hand, demonstrated a break from reality in the form of hallucinations, delusions, or grossly disorganized thinking (common in what we would now call schizophrenia) (Reisman, 1991).

Emil Kraepelin (1855–1926), considered the "father of descriptive psychiatry" (Reisman, 1991, p. 30), offered a different two-category system of mental illness. Kraepelin differentiated **exogenous disorders** (caused by external factors) from **endogenous disorders** (caused by internal factors) and suggested that exogenous disorders were the far more treatable type. Kraepelin also assigned names to specific examples of disorders in the broad exogenous or endogenous categories. For example, Kraepelin put forth the term **dementia praecox** to describe one endogenous disorder similar to what is now known as schizophrenia. Later, he also proposed terms
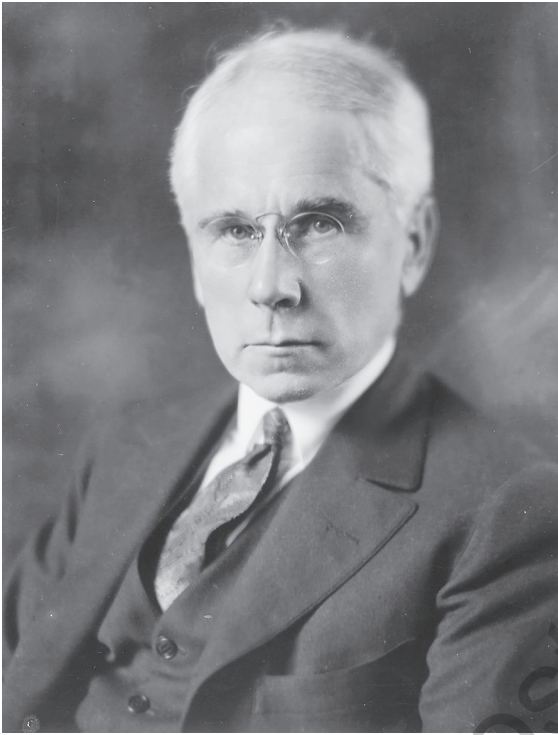
Lightner Witmer (1867–1956), who created the term *clinical psychology* and founded the first psychological clinic. How has the field changed since Witmer's era?

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such as *paranoia, manic depressive psychosis, involutional melancholia, cyclothymic personality*, and *autistic personality*—terms that had not previously been coined (Millon & Simonsen, 2010). Most of Kraepelin's specific terms have long since been replaced, but by offering such specific terminology, he set a precedent for the creation of diagnostic terms that eventually led to the ***Diagnostic and Statistical Manual of Mental Disorders (DSM***; Engstrom & Weber, 2015; Widiger & Mullins-Sweatt, 2008).

In the United States, long before the appearance of the first *DSM*, the original reason for categorizing mental disorders was to collect statistics on the population. In 1840, the U.S. Census Bureau included a single category—"idiocy/insanity"—for this purpose. In 1880, there were seven such categories, and soon the American Medical Association and the U.S. Army each made preliminary attempts at classifying mental illness (American Psychiatric Association, 2000).

The original *DSM* was published by the American Psychiatric Association in 1952, representing a more sophisticated attempt to define and organize mental diagnoses. A revision (*DSM-II*) followed in 1968, but it was not considered to be significantly different from the original. However, the next revision—*DSM-III*, which arrived in 1980—signified a fundamentally different way of thinking about mental disorders (Decker, 2013). Where *DSM* and *DSM-II* included somewhat vague descriptions of each disorder, *DSM-III* provided specific **diagnostic criteria**—lists indicating exactly what symptoms constitute each disorder. The *DSM* has been revised several more times, with *DSM-III-R, DSM-IV, DSM-IV-TR,* and *DSM-5* appearing in 1987, 1994, 2000, and 2013, respectively. The current edition is *DSM-5-TR*, which was published in March 2022. *DSM-5-TR* is considered a minor revision, but *DSM-5* was a major revision with lots of new disorders, and when it arrived in 2013 it was accompanied by significant anticipation and controversy. (*DSM-5* and *DSM-5-TR* will be covered in more detail elsewhere, especially in Chapter 7.) Each edition differs from its predecessor to some extent, but the most drastic change occurred with

the publication of *DSM-III* in 1980 (Horwitz, 2020, 2021; Lilienfeld & Landfield, 2008a; Widiger & Mullins-Sweatt, 2008).

Sheer size is certainly among the most notable differences between *DSM-II* and *DSM-III*. In fact, new *DSM*s typically include more disorders than the editions they replace, with the jump between *DSM-II* and *DSM-III* being the largest. In the time between the original *DSM* (in 1952) and *DSM-IV* (in 1994), the number of disorders increased by more than 300% to a total of 368 distinct diagnoses covering an increasing scope of human behavior (Houts, 2002). The first two editions of the *DSM* were brief, spiral-bound books; the current *DSM* is well over 1,000 pages long.

What are the reasons for such an increase in size? On the one hand, it is possible that in a relatively brief period of time, psychological science is accurately recognizing and adding disorders that went unrecognized (or at least unlabeled) for centuries before, an explanation called "scientific discovery." On the other hand, it is also possible that psychology is creating disorders out of certain aspects of human experience that had previously been considered nondisordered, an explanation called "social invention" (Houts, 2002). Ongoing debates have arisen regarding the relative truth of both explanations. Debates also continue regarding the expanding range of the *DSM*, in general, and the inclusion and exclusion of some specific disorders as well. Some of these debates call into question the extent to which factors other than empirical data drive the decision making of *DSM* authors, and the histories of certain disorders—some of which appear in the *DSM*, and some of which do not— have been offered as evidence (Caplan, 1995; Eriksen, 2005; Horwitz, 2020, 2021; Kutchins & Kirk, 1997). The next section in this chapter illustrates some of the decisions represented in *DSM* revisions. Regardless of the outcomes or current status of diagnostic debates (some of which are discussed in more detail in later chapters), recent *DSM* revisions represent important chapters of a long history of diagnostic labeling that characterizes clinical psychology.

### Is It a DSM Disorder? Decisions to Include or Exclude Potential Disorders

Before each edition of the *DSM* is published, its authors oversee an extensive process during which they must, among other important tasks, decide whether or not to add certain experiences or sets of symptoms as official diagnoses. The implications of these classification decisions are quite significant for many people, including clients who could be assigned the new diagnosis, mental health professionals who may treat them, health insurance companies who may pay for the treatment, and researchers who could study the new diagnosis.

Many times, *DSM* authors have decided to add an entirely new disorder. For example, when *DSM-5-TR* arrived in 2022, it included a new disorder—prolonged grief disorder, in which the person continues to grieve or mourn for a lost loved one much more intensely and for a much longer time than would be expected (at least 1 year for adults, at least 6 months for kids). Also, borderline personality disorder, narcissistic personality disorder, and social phobia each appeared for the first time in *DSM-III* in 1980. At other times, *DSM* authors have, after serious consideration, decided not to include a proposed set of symptoms as an official disorder. For example, for years prior to the publication of *DSM-IV, DSM* authors contemplated adding disorders tentatively named sadistic personality disorder and self-defeating personality disorder, among others, but ultimately decided against them. On occasion, the *DSM* authors reverse a

previous decision to include a disorder—in other words, they remove a disorder that had been included in previous editions. For example, "homosexuality" (as being gay or lesbian was called at the time) was listed as a disorder in *DSM-I* and *DSM-II* but was excluded from *DSM-III* (and subsequent editions) after extensive controversy.

A section of the current edition of the *DSM* (*DSM-5-TR*) lists numerous proposed disorders that were considered for inclusion but rejected by *DSM* authors. They are included as unofficial "conditions for further study" with the hope that additional research will inform future decisions to include or exclude them as official disorders. Included among these proposed disorders are the following (American Psychiatric Association, 2022):

- *Internet gaming disorder*, in which the person's Internet game-playing behavior causes clinically significant impairment or stress. The person is preoccupied with gaming, can't control their gaming behavior, experiences withdrawal when access is taken away, experiences relationship problems due to gaming, or has similar symptoms.

- *Attenuated psychosis syndrome*, in which the person experiences mild or brief delusions, hallucinations, or other psychotic phenomena. These are the same kinds of symptoms experienced by people with schizophrenia, but in attenuated psychosis syndrome, the symptoms would be more fleeting, less intense, and the person's perception of reality would remain largely intact. (*Attenuated* means reduced or lessened.)

- *Nonsuicidal self-injury disorder*, which can involve cutting, burning, or otherwise intentionally hurting one's own body without the intent to kill oneself, on 5 or more days in the last year. This behavior has long been recognized as a symptom of other disorders (especially borderline personality disorder), but with this proposed disorder, nonsuicidal self-injury would be a full-fledged disorder of its own.
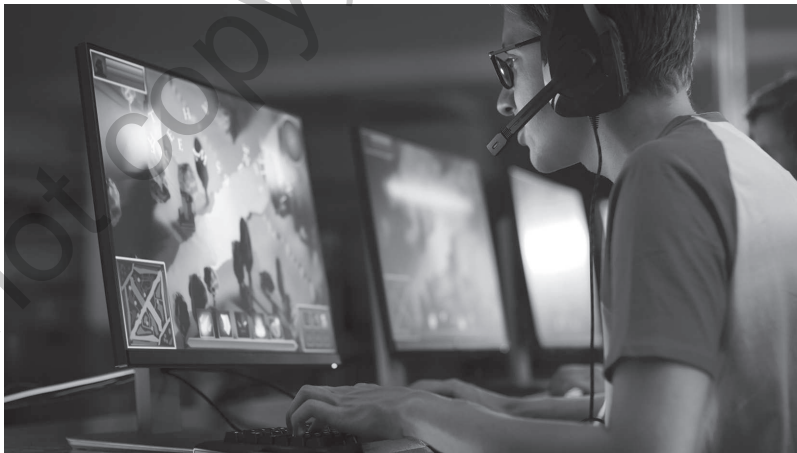
What distinguishes a strong passion for video games, or other common but potentially problematic experiences, from mental illness?

istock/ gorodenkoff

There is no doubt that many individuals experience the phenomena described in these "proposed criteria sets." The question is whether these experiences should be categorized as forms of mental illness or understood to be part of the range of normal human experience. Whether these experiences will be classified as official disorders in a future edition of *DSM* depends, ultimately, on decisions made by the *DSM* authors.

Assessment of Intelligence

The emergence of the field of clinical psychology around the turn of the 20th century coincided with a dispute among psychology's pioneers about the nature of intelligence. **Edward Lee Thorndike** was among those who promoted the idea that each person possesses separate, independent intelligences, whereas **Charles Spearman** led a group of theorists who argued for the existence of "g," a general intelligence thought to overlap with many particular abilities (Reisman, 1991). The outcome of this dispute would profoundly influence how clinical psychologists assessed intellectual abilities—an activity that, more than psychotherapy or any other activity, characterized clinical psychology as a profession in the early years of the profession (Benjamin, 2007).

An important development in the history of intelligence testing arose in the early 1900s, when the French government sought help in determining which public school students should qualify for special services. In response to this request, **Alfred Binet** (along with Theodore Simon) created the first Binet-Simon scale in 1905 (Ferrand & Nicolas, 2015). This test yielded a single overall score, endorsing the concept of "g." It was the first to incorporate a comparison of mental age to chronological age as a measure of intelligence. This comparison, when expressed as a division problem, yielded the "intelligence quotient," or IQ. Binet's test grew in popularity and was eventually revised by Lewis Terman in 1937. Terman's revision was called the **Stanford-Binet Intelligence Scales**, the name by which the test is currently known (Goldstein, 2008; Reisman, 1991).

The standardization sample and the age range of test takers improved with each new version of Binet's test, but even after Terman revised it in 1937, it was still a child-focused measure of IQ. In 1939, **David Wechsler** filled the need for a test of intelligence designed specifically for adults with the publication of his **Wechsler-Bellevue** test. It quickly became popular among psychologists working with adults, and its more recent revisions remain popular today. Since its creation, Wechsler's adult intelligence scale has been revised and restandardized numerous times: the **Wechsler Adult Intelligence Scale (WAIS)** in 1955, the WAIS-R in 1981, the WAIS-III in 1997, and the WAIS-IV in 2008 (Goldstein, 2008; Reisman, 1991; Wasserman & Kaufman, 2015).

In 1949, Wechsler released a children's version of his intelligence test (a more direct competitor for the Stanford-Binet), which he called the **Wechsler Intelligence Scale for Children (WISC)**. The WISC distinguished itself from the Stanford-Binet by the inclusion of specific subtests as well as verbal and performance scales (in addition to overall IQ). The WISC has been revised and restandardized several times: the WISC-R in 1974, the WISC-III in 1991, the WISC-IV in 2003, and the WISC-V in 2014. In 1967, Wechsler added an intelligence

test designed for very young children called the **Wechsler Preschool and Primary Scale of Intelligence (WPPSI)**. The WPPSI was revised in 1989 (WPPSI-R), 2002 (WPPSI-III), and 2012 (WPPSI-IV).

Many other measures of child and adult intelligence have appeared during the time of the Stanford-Binet and the Wechsler tests, but more than any others, these two have established themselves as standards in the field. They have also established themselves as competitors in the marketplace of psychological assessment, and recent revisions in one have at times represented responses to successful strides made by the other.

Assessment of Personality

The term *mental test* was first used by James McKeen Cattell in 1890 in an article titled "Mental Tests and Measurements" (Cattell, 1890). At that time, the term was used to refer to basic tests of abilities such as reaction time, memory, and sensation/perception. Soon, though, the term encompassed a wider range of measures, including not only the intelligence tests described above but also tests of personality characteristics (Butcher, 2010).

The first two decades of the 20th century witnessed some of the earliest attempts to measure personality attributes empirically, but few had much impact. In 1921, however, **Hermann Rorschach** published a test that had significant impact for many years to come. Rorschach, a Swiss psychiatrist, released his now-famous set of 10 inkblots, which rose quickly in popularity (despite the fact that in the early years, several different competing Rorschach scoring systems existed). As a **projective personality test**, the **Rorschach Inkblot Method** was based on the assumption that people will "project" their personalities onto ambiguous or vague stimuli; in other words, the way individuals perceive and make sense of the blots corresponds to the way they perceive and make sense of the world around them. Psychodynamic psychologists, who dominated during the early and mid-1900s, found such tests especially compatible with their clinical approach to clients.

The success of Rorschach's test was followed by a number of other projective techniques (Reisman, 1991). For example, **Christiana Morgan** and **Henry Murray** published the **Thematic Apperception Test (TAT)** in 1935. The TAT was similar to the Rorschach in that the test taker responded to cards featuring ambiguous stimuli. However, instead of inkblots, the TAT cards depicted people in scenes or situations that could be interpreted in a wide variety of ways. Instead of identifying objects in the card (as they might with Rorschach's inkblots), clients were asked to tell stories to go along with the interpersonal situations presented in the TAT cards. Again, their responses were thought to reflect personality characteristics. Other projective techniques that appeared in the aftermath of the Rorschach included the Draw-a-Person test, in which psychologists infer personality characteristics from clients' drawings of human figures, and Julian Rotter's Incomplete Sentence Blank (Rotter & Rafferty, 1950), in which psychologists assess personality by examining the ways clients finish sentence stems. Like the Rorschach, these and other projective personality tests have certainly enjoyed some degree of popularity, but their usage has declined in recent decades as questions about their reliability and validity have accumulated.

Objective personality tests appeared soon after projectives, offering a very different (and, in many cases, more scientifically sound) method of assessing personality. Typically, these tests were pencil-and-paper instruments for which clients answered multiple-choice or true–false questions about themselves, their experiences, or their preferences. Scoring and interpretation were typically more straightforward than for projective tests. Some objective tests focused on specific aspects of personality, whereas others aimed to provide a more comprehensive overview of personality. The **Minnesota Multiphasic Personality Inventory (MMPI)**, written by **Starke Hathaway** and **J. C. McKinley**, is perhaps the best example of a comprehensive personality measure. When it was originally published in 1943, it consisted of 550 true–false statements. Test takers' patterns of responses were compared with those of groups in the standardization sample who represented many diagnostic categories. Not only could this test help a psychologist categorize a client through use of its clinical scales, it also used validity scales to assess the test taker's approach to the test. In other words, the MMPI had a built-in system to detect random responding or intentionally misleading responses. The MMPI became very popular, and by 1959 there were more than 200 separate scales consisting of combinations of MMPI items (Reisman, 1991).

In 1989, the **Minnesota Multiphasic Personality Inventory-2 (MMPI-2)** was released. Its norms were more appropriate than those of the original MMPI, especially in terms of including minorities and individuals from various regions of the country in the standardization sample. It also eliminated some of the outdated or confusing language from the original test. An adolescent version of the test (the **Minnesota Multiphasic Personality Inventory-Adolescent [MMPI-A]**) followed in 1992. All versions of the MMPI have featured hallmarks of high-quality objective personality tests: easy administration and scoring, demonstrable reliability and validity, and clinical utility.

Other objective tests have come and gone but none with the lasting impact or research base of the MMPI. The NEO Personality Inventory (NEO-PI), for example, and its successors, the NEO-PI-R and NEO-PI-3, have risen to some degree of prominence in more recent decades as a personality measure less geared toward psychopathology than is the MMPI (Costa & McCrae, 1985, 1992; McCrae et al., 2005). Rather than diagnostic categories, its scales are based on universal personality characteristics common to all individuals (the "big five" personality factors). Instruments measuring more specific states or traits have also appeared, including the Beck Depression Inventory (now in its second edition) and the Beck Anxiety Inventory (Beck et al., 1996; Beck & Steer, 1993).

In recent decades, personality assessment tools have been used for an increasingly wider range of purposes, including job screenings and forensic purposes (e.g., child custody evaluations; Butcher, 2010). These uses have often generated significant controversy and highlight the importance of validity and reliability in such tests—topics we cover in more detail in Chapter 6.

PSYCHOTHERAPY

Psychotherapy is the primary activity of clinical psychologists today, but that hasn't always been the case. In fact, in 1930—more than a quarter century after Witmer founded the field—almost every clinical psychologist worked in academia (rather than as a practitioner),

and it wasn't until the 1940s or 1950s that psychotherapy played a significant role in the history of clinical psychology (Benjamin, 2005; Farreras, 2016; Humphreys, 1996; McFall, 2006; Vasquez & Kelly, 2016; Wertheimer, 2000). In fact, in the first half of the 1900s, psychological testing was familiar territory for clinical psychologists, "but it was important that they knew their place in a field dominated by medical practitioners . . . a strategy for treatment, and treatment—those were in the job description of the physician, not the psychologist" (Benjamin, 2007, p. 163). Without the demand created by the psychological consequences of World War II on U.S. soldiers, psychotherapy might have remained an uncommon activity for clinical psychologists even longer (Bazar, 2015b; Bazar, 2015c; Benjamin, 2007; Farreras et al., 2016). (The next section in this chapter offers further exploration of the impact of war on the history of clinical psychology.)

In the middle of the 20th century, when psychotherapy rose to a more prominent place in clinical psychology, the **psychodynamic** approach to therapy dominated (Routh, 1996). With time, challengers to the psychodynamic approach emerged (Engel, 2008; Hollon & DiGiuseppe, 2011; Routh, 2011). In the 1950s and 1960s, for example, behaviorism surfaced as a fundamentally different approach to human beings and their behavioral or emotional problems. The **behavioral** approach emphasizes an empirical method, with problems and progress measured in observable, quantifiable terms. This emphasis was in part a reaction to the lack of empiricism evident in psychodynamic psychotherapy. **Humanistic** (or "client-centered") therapy also flourished in the 1960s, as Carl Rogers's relationship- and growth-oriented approach to therapy offered an alternative to both psychodynamic and behavioral approaches that many therapists and clients found attractive. The **family therapy** revolution took root in the 1950s, and as the 1960s and 1970s arrived, understanding mentally ill individuals as symptomatic of a flawed system had become a legitimate—and, by some clinicians, the preferred—therapeutic perspective.

More recently, interest in **cognitive** therapy, with its emphasis on logical thinking as the foundation of psychological wellness, has intensified to the point that it has become the most popular singular orientation among clinical psychologists (excluding eclectic or integrative approaches; Engel, 2008; Norcross & Karpiak, 2012; O'Donohue, 2009). Perhaps the most striking feature of the current therapy marketplace is the utter range of therapy approaches. To illustrate, modern graduate textbooks for psychotherapy courses typically include at least a dozen chapters on distinct approaches (e.g., Barkham et al., 2021; Consoli et al., 2017; Corey, 2020), with each chapter representing a full spectrum of more specific variations.

In addition to the sequential rise of these therapy approaches, recent decades have witnessed a movement toward combining them, in either eclectic or integrative ways (Gilbert, 2019; Goldfried et al., 2011), as well as the tremendous influence of cultural competence and diversity-related skills on any and all such approaches (Comas-Díaz, 2011a; Sue et al., 2022).

Many of these therapy approaches are covered in detail elsewhere in this book, but for now, the important point is that the plethora of therapy options currently available to clinical psychologists did not always exist. Rather, these methods have evolved over the history of the discipline, with each new therapy approach emerging from the context of—and often as a reaction against—the therapies that came before it.

War has influenced the field of clinical psychology in numerous ways. For soldiers involved in direct combat, how might clinical psychologists be most helpful?

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The Influence of War on Clinical Psychology

It is difficult to overestimate the influence of war and its aftermath on the development of clinical psychology as a profession. Therapy, assessment, and training have all been shaped by the attempts of various governments and individuals to select soldiers and treat them after they have served their countries (Baker & Pickren, 2011; Bazar, 2015a; Bazar, 2015c; Benjamin, 2007; Tryon, 2008). In fact, one researcher makes the claim that the history of the entire mental health field (including clinical psychology) is not "characterized by the slow, incremental growth of knowledge, but by bursts of knowledge generated during wars" (Grinker, 2021, p. xxvi). Numerous critical incidents in the history of clinical psychology can be directly tied to military factors:

- Robert Yerkes chaired the Committee on the Psychological Examination of Recruits that created the Army Alpha and Beta intelligence tests during World War I. These tests, which were used to measure the intelligence of recruits and soldiers, are considered precursors to today's most widely used measures of intelligence (McGuire, 1994).

- David Wechsler's creation of the Wechsler-Bellevue, his first intelligence test, stemmed from his clinical experiences during World War I measuring intellectual capacities of military personnel. This test led to the WAIS, and ultimately the WISC and WPPSI, the revisions of which are currently the most widely used measures of adult and child intelligence in the United States (Boake, 2002; Reisman, 1991).

- In response to World War II, President Harry Truman ordered the military to create a manual of psychological diagnoses to make sure there was a common language for all of the psychologists (and others) who treated or did research on the problems soldiers experienced. That manual became the first edition of the *DSM*, which was eventually used widely in the general population and the subsequent editions of which are now used throughout the United States by mental health professionals (Grinker, 2021).

- In the aftermath of World War II, many U.S. veterans returned home with "shell shock," as it was called at the time, and other psychological effects of battle (Benjamin, 2005; Farreras et al., 2016; Miller, 1946). (*Posttraumatic stress disorder* later replaced *shell shock* as the accepted diagnostic label.) The U.S. government (specifically, the Veterans Administration—now the Department of Veterans Affairs) responded by requesting that the American Psychological Association formalize the training of clinical psychologists and provided significant funding to ensure the availability of such training opportunities. These efforts led to accreditation of clinical psychology doctoral training programs and ultimately to the scientist-practitioner (i.e., Boulder) model of training. This training model continues to loom large in the field, and the strong relationship between Veterans Affairs and clinical psychology training—including a large number of internships at various levels—continues as well (Baker & Pickren, 2011; Humphreys, 1996; Kutchins & Kirk, 1997). By 2014, there were 4,700 psychologists (including both clinical psychologists and counseling psychologists) working within the Department of Veterans Affairs, and by 2022 that number was nearly 6,000 (Boyd, 2022; Zeiss et al., 2016).

- The Nazi presence in Eastern Europe in the 1930s forced many influential figures in clinical psychology—including Sigmund Freud and other Jewish psychodynamic leaders—to flee their home countries. This forced relocation facilitated the spread of their theories and clinical approaches to England and, ultimately, to the United States (Reisman, 1991).

- Recent U.S. military events, including efforts in Iraq and Afghanistan, have illustrated the crucial role that clinical psychologists continue to play for soldiers and veterans (Lorber & Garcia, 2010; Maguen et al., 2010; Moore, 2019). In fact, Veterans Affairs is one of the country's largest providers of mental health services, with about 28% of veterans of major military operations between 2001 and 2010 receiving VA mental health services (National Academies of Sciences, Engineering, and Medicine, et al., 2018).

Consider the most recent missions carried out by U.S. military personnel. How will the profession of clinical psychology be shaped by these activities? What needs will clinical psychologists be challenged to meet, and how do these needs compare to those stemming from early war-related activities? Besides military personnel themselves, who might benefit from the services of clinical psychologists in relation to these activities?

DEVELOPMENT OF THE PROFESSION

Just as clinical psychology's primary activities, such as psychotherapy and assessment, have evolved, the profession itself has progressed since its inception. Even in the earliest years, significant steps were evident. For example, in 1917, the American Association of Clinical Psychologists was founded, and in 1919 it transitioned into the Clinical Section of the American Psychological Association. In 1921, the Psychological Corporation was founded, foreshadowing the big business that was to become of psychological tests and measures of intelligence and personality.

In the 1940s, education and training in clinical psychology became more widespread and more standardized. The number of training sites increased dramatically, and the American Psychological Association began accrediting graduate programs that offered appropriate training experiences in therapy, assessment, and research. VA hospitals began their long-standing relationship with clinical psychology by funding graduate training and internships. And in 1949, the historic **Boulder conference** took place, at which training directors from around the country agreed that both practice and research were essential facets of PhD clinical psychology training (Cautin, 2011).

The 1950s produced more evidence that clinical psychology was a flourishing profession. Therapy approaches proliferated, with new behavioral and humanistic/existential approaches rivaling established psychodynamic techniques. The extent to which psychotherapy did or did not work also received increased attention, kick-started by Eysenck's (1952) critical analysis. The American Psychological Association published the first edition of its ethical code in 1953, with significant discussion of clinical activities, reflecting a new level of professional establishment for clinical psychology (McFall, 2006; Tryon, 2008).

In the 1960s and 1970s, the profession of clinical psychology continued to diversify, successfully recruiting more women and members of various ethnic and racial groups into the field. Clinical approaches continued to diversify as well, as behaviorism, humanism, and dozens of other approaches garnered large followings. The first PsyD programs appeared, offering graduate training options that emphasized applied clinical skills over research expertise. And signifying that psychotherapy was becoming a recognized part of American health care, health insurance companies began to authorize payment for clinical psychologists' services just as they did for the services of many medical specialists.

In the 1980s, clinical psychologists enjoyed increased respect from the medical establishment as they gained hospital admitting privileges and Medicare payment privileges. Larger numbers of graduate training institutions continued to train larger numbers of new clinical psychologists, and the number of American Psychological Association members who were clinicians approached 50%. Psychotherapy prospered, especially in private practice settings, but the use of intelligence and personality testing decreased (Reisman, 1991). The growth of the profession continued through the 1990s, 2000s, and 2010s, as did the trend toward diversity in gender and ethnicity of those joining it (DeLeon et al., 2011; Norcross & Karpiak, 2012).

The size and scope of the field continues to grow, largely to meet the demand for psychotherapy services. In the late 1950s, only 14% of the U.S. population had ever received any kind

of psychological treatment; by 2010, that number had climbed to 50%. In 2020 alone, over 20% of U.S. adults received some kind of mental health treatment, including over 10% who received psychotherapy or counseling (Terlizzi & Norris, 2021). Professional training options continue to multiply as well. Today's aspiring clinical psychologists have more choices than ever: the science/practice balance of traditional PhD programs, PsyD programs emphasizing clinical skills, and a subset of PhD programs that endorse the clinical scientist model of training and lean heavily toward the empirical side of the science/practice continuum (Klonoff, 2011; McFall, 1991; Norcross & Sayette, 2022; Stricker, 2011). Numerous specializations, including forensic psychology and health psychology (illustrated by the inclusion of increasing numbers of clinical psychologists on primary health care teams), are flourishing. The emphasis on diversity, equity, and inclusion has grown remarkably within the field (Hays, 2022; Sue et al., 2022). Empirical support for clinical techniques, interest in prescription privileges, and new technologies such as telepsychology (as described in Chapter 3) are among the other major professional developments in recent years.

To summarize the events described in this chapter, the table below presents a timeline of important events in the history of clinical psychology.

TABLE 2.1 ■ Timeline of Key Historical Events in Clinical Psychology	
Year	**Event**
1796	William Tuke opens York Retreat in England
1801	Philippe Pinel publishes book on humane treatment of mentally ill (*Medico-Philosophical Treatise on Mental Alienation or Mania*)
1824	Eli Todd opens The Retreat in Hartford, Connecticut
1840	U.S. Census Bureau lists one category of mental disorder ("idiocy/insanity")
1841	Dorothea Dix encounters mentally ill in Boston prison, prompting extensive efforts for better treatment
1880	U.S. Census Bureau lists seven categories of mental disorders
1890	"Mental test" is used in print for the first time by Cattell
1892	Lightner Witmer earns his doctoral degree
1893	Emil Kraepelin proposes the early diagnostic category "dementia praecox"
1896	Lightner Witmer opens the first psychological clinic at the University of Pennsylvania
1905	Binet-Simon intelligence test is published in France
1907	Lightner Witmer founds the first professional journal of clinical psychology, *The Psychological Clinic*

Year	Event
1914	Psychology clinics proliferate; about 20 in operation
1916	Stanford-Binet Intelligence Test (as translated by Terman) is published in the United States
1917	American Association of Clinical Psychologists is founded
1921	Psychological Corporation is founded
1921	Rorschach inkblot technique published
1930s to 1950s	Psychoanalysis dominates psychotherapy
1935	Thematic Apperception Test published
1935	Psychology clinics proliferate further; more than 150 in operation
1939	Wechsler-Bellevue Intelligence Test published; first designed for adults
1943	Minnesota Multiphasic Personality Inventory (MMPI) published
1949	Wechsler Intelligence Test for Children (WISC) published
1949	Boulder conference held; yields scientist-practitioner training model
1950s to 1970s	Alternatives to psychoanalytic psychotherapy emerge (e.g., behaviorism, humanism, family/systems)
1952	Hans Eysenck publishes early, critical review of psychotherapy outcome
1952	*Diagnostic and Statistical Manual of Mental Disorders (DSM)* published
1953	American Psychological Association publishes first ethical code
1955	Wechsler Adult Intelligence Scale (WAIS) published
1967	Wechsler Preschool and Primary Scale of Intelligence (WPPSI) published
1968	*DSM-II* published
1973	Vail conference held; yields PsyD and practitioner-scholar training model
1974	WISC-R published
1980s to 2000s	Cognitive psychotherapy rises in prominence
1980	*DSM-III* published; specific diagnostic criteria and multiple axes appear
1981	WAIS-R published
1985	NEO Personality Inventory (NEO-PI) published
1987	*DSM-III-R* published
1989	MMPI-2 published

(*Continued*)

TABLE 2.1 ■ Timeline of Key Historical Events in Clinical Psychology (*Continued*)	
Year	**Event**
1989	WPPSI-R published
1991	Richard McFall publishes "manifesto" that produces "clinical scientist" training model
1991	WISC-III published
1992	MMPI-A published
1994	*DSM-IV* published
1997	WAIS-III published
1999	NEO-PI-R published
2000	*DSM-IV-R* published
2002	WPPSI-III published
2003	WISC-IV published
2008	WAIS-IV published
2008	MMPI-2-RF published
2013	*DSM-5* published
2022	*DSM-5-TR* published

CHAPTER SUMMARY

The roots of clinical psychology can be traced to pioneering efforts in the late 1700s and 1800s by William Tuke, Philippe Pinel, Eli Todd, Dorothea Dix, and others to treat people with mental illness in a humane rather than punitive way. The field of clinical psychology was formally founded by Lightner Witmer, who founded the first psychological clinic at the University of Pennsylvania in 1896 and created the first professional journal devoted to clinical psychology in 1907. The history of clinical psychology has been tarnished by numerous acts of racism and prejudice, but efforts to acknowledge those acts and behave more inclusively and equitably have increase in recent years. Early efforts to diagnose mental problems were quite rudimentary, but the work of Emil Kraepelin and others eventually led to more sophisticated diagnostic classification systems, culminating in the current edition of the *DSM* (*DSM-5*), which defines hundreds of disorders according to specific diagnostic criteria. The assessment of intelligence has evolved from the earliest work of Alfred Binet, David Wechsler, and others to the current editions of their tests, such as the Stanford-Binet and the WAIS,

WISC, and WPPSI. Early attempts to assess personality were primarily projective tests, such as the Rorschach inkblot method and the TAT. Those tests were soon followed by objective personality tests such as the MMPI, many of which have achieved high levels of reliability and validity. Although psychotherapy is currently the dominant professional activity of clinical psychologists, it was relatively uncommon until the 1940s and 1950s. At that time, the psychodynamic approach to therapy prevailed, but behaviorism and humanism rose to popularity in the decades that followed. Currently, the cognitive approach is the most popular single-school therapy approach, and the number of distinct approaches to therapy continues to grow, as does the emphasis on issues of diversity and cultural competence for therapists. The evolution of psychotherapy and other prominent aspects of clinical psychology has been significantly affected by war. As a profession, clinical psychology continues to evolve in many ways, including a diversification of its members and its graduate training options.

KEY TERMS AND NAMES

Alfred Binet (p. 37)

behavioral (p. 40)

Boulder conference (p. 43)

Charles Spearman (p. 37)

Christiana Morgan (p. 38)

cognitive (p. 40)

David Wechsler (p. 37)

dementia praecox (p. 33)

Diagnostic and Statistical Manual of Mental Disorders (DSM) (p. 34)

diagnostic criteria (p. 34)

Dorothea Dix (p. 29)

Edward Lee Thorndike (p. 37)

Eli Todd (p. 29)

Emil Kraepelin (p. 33)

endogenous disorders (p. 33)

exogenous disorders (p. 33)

family therapy (p. 40)

Henry Murray (p. 38)

Hermann Rorschach (p. 38)

humanistic (p. 40)

J. C. McKinley (p. 39)

Lightner Witmer (p. 30)

Minnesota Multiphasic Personality Inventory (MMPI) (p. 39)

Minnesota Multiphasic Personality Inventory-2 (MMPI-2) (p. 39)

Minnesota Multiphasic Personality Inventory-Adolescent (MMPI-A) (p. 39)

neurosis (p. 33)

objective personality tests (p. 39)

Philippe Pinel (p. 28)

projective personality test (p. 38)

psychodynamic (p. 40)

psychosis (p. 33)

Rorschach Inkblot Method (p. 38)

Stanford-Binet Intelligence Scales (p. 37)

Starke Hathaway (p. 39)

The Psychological Clinic (p. 30)

The Retreat (p. 29)

Thematic Apperception Test (TAT) (p. 38)

Wechsler Adult Intelligence Scale (WAIS) (p. 37)

Wechsler Intelligence Scale for Children (WISC) (p. 37)

Wechsler Preschool and Primary Scale of Intelligence (WPPSI) (p. 38)

Wechsler-Bellevue (p. 37)

William Tuke (p. 28)

York Retreat (p. 28)

CRITICAL THINKING QUESTIONS

1. How essential were the contributions of William Tuke, Philippe Pinel, Eli Todd, and Dorothea Dix to the creation of the field of clinical psychology? Would the field exist today without their work?

2. Psychotherapy was not even mentioned in Lightner Witmer's original definition of clinical psychology, but in recent decades, psychotherapy has been the most common activity of clinical psychologists. In your opinion, what factors might have contributed to the rise in prominence of psychotherapy?

3. In your opinion, why has the number of disorders defined by successive editions of the *DSM* continued to increase?

4. In your opinion, which of the current proposed disorders (as listed in the section entitled "Is It a *DSM* Disorder? Decisions to Include or Exclude Potential Disorders") should be included as official disorders in the next edition of the *DSM?* On what do you base your opinion?

5. To what extent would you expect a graduate program's model of training (e.g., scientist-practitioner, practitioner-scholar, or clinical scientist) to influence the types of personality assessment tools (e.g., projective or objective) it trains its students to use?

KEY JOURNALS

History of Psychology

Journal of Clinical Psychology

Journal of the History of the Behavioral Sciences