Stefan G. Hofmann *Editor*

International Perspectives on Psychotherapy

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Introduction: International Perspectives on Psychotherapy

After returning from Wilhelm Wundt's laboratory in Germany, Lightner Witmer introduced the term *Clinical Psychology* in an article published in The Psychological Clinic (Witmer, 1907). In this article, he explained:

> While the term 'clinical' has been borrowed from medicine, clinical psychology is not a medical psychology. I have borrowed the word 'clinical' from medicine, because it is the best term I can find to indicate the character of the method which I deem necessary for this work (p. 251).

Witmer, who later became one of the cofounders of the *American Psychological Association*, thought that the goal of clinical psychology should be similar to that of medicine to improve the human condition (Witmer, 1897). This notion significantly expanded the boundaries of the young discipline, which was primarily defined by experimental psychology to simply study the nature of psychological phenomena (McReynolds, 1997).

Despite the early call for intervention and prevention of human suffering, training in clinical psychology primarily focused on psychological assessments during the first half of the twentieth century. The emphasis shifted more toward intervention after World War II, when there was a greater need for clinicians. However, psychoanalysis dominated the field of psychotherapy during those early years. Furthermore, early editions of the *Diagnostic and Statistical Manual* were firmly rooted in psychoanalytic concepts with little to no empirical support. This changed with the publication of the DSM-III (APA, 1980) and especially the DSM-III-R (APA, 1987) when psychoanalysis began to lose its dominance on the psychiatric classification system. Moreover, behavior therapy became more prominent with work by Skinner (1969), Wolpe (1958), and many others demonstrating the clear efficacy of applying theory-based behavioral principles toward modifying maladaptive behaviors. The focus on empirical evidence for treating mental disorders was further strengthened with the integration of cognitive ideas into what has become known as cognitive behavioral therapy (CBT; Beck, 1970). Since then, CBT evolved into a broad family of empirically supported treatments that share a mature set of principles and techniques firmly rooted in theoretical models and supported by empirical evidence (for an overview, see Hofmann, Asmundson, & Beck, 2013).

These developments raised obvious and important question about how to develop training models for future generations of clinical psychologists. In the USA, the 1949 Boulder conference marked one of many important milestones in this developmental process. The consensus of this conference was to officially recognize that clinical psychology training programs should emphasize both the practice and the science of the profession, which became known as the *scientist-practitioner model* (Raimy, 1950). Today, the APA defines *clinical psychology* as

> The psychological specialty that provides continuing and comprehensive mental and behavioral health care for individuals and families; consultation to agencies and communities; training, education and supervision; and research-based practice. It is a specialty in breadth—one that is broadly inclusive of severe psychopathology—and marked by comprehensiveness and integration of knowledge and skill from a broad array of disciplines within and outside of psychology proper. The scope of clinical psychology encompasses all ages, multiple diversities and varied systems (APA, 2016).

This broad definition acknowledges the diverse field of clinical psychology. It includes services to individuals and groups from all ethnic, cultural, and socioeconomic backgrounds. A similar approach has been pursued by the Association for Psychological Science (APS), which places a relatively greater emphasis on the science of clinical psychology. Contemporary clinical psychology is a reflection of today's complex society. Although the USA has had a major role in the development of this discipline, there have been many influences from across the world that contributed to its current state. However, trainings of mental healthcare professionals have been primarily limited to a specific geographic region and culture. The objective of this book is to compare the status of clinical psychology in different countries across the word. The primary goal is to learn from each other in order to further advance the field of clinical psychology worldwide.

The first two chapters provide a general and condensed introduction of psychopathology and classification (Chap. 1 by Sharon Eldar, Angelina F. Gómez, and Stefan G. Hofmann) and psychotherapy approaches (Chap. 2 by Barbara Depreeuw, Sharon Eldar, Kristina Conroy, and Stefan G. Hofmann). These chapters are followed by a review of clinical psychology in the various regions of the world, including North America (Chap. 3 by Elaine S. Lavin and Lata K. McGinn), Central Europe (Chap. 4 by Ilse Kryspin-Exner, Oswald D. Kothgassner, and Anna Felnhofer), Eastern Europe (Chap. 5 by Daniel David and Simona Stefan), Latin America (Chap. 6 by Carmem Beatriz Neufeld and Anelisa Vaz de Carvalho), South Korea (Chap. 7 by Sunyoung Kim and Hyun Kim), China (Chap. 8 by Jianping Wang, Zhiyun Wang, and Meng Yu), Australia (Chap. 9 by Caroline Hunt), Africa (Chap. 10 by Maxine F. Spedding, Dan J. Stein, and Katherine R. Sorsdahl), and the Middle East (Chap. 11 by Asala Halaj and Jonathan D. Huppert). Chapter 12 by Jennifer Prentice, Keith Dobson, and Janel Gauthier discusses ethics from a global perspective.

Mental health knows no borders, and effective treatments should similarly travel freely across the globe. My hope is that this volume contributes to the globalization

of mental health by initiating an exchange of ideas between different countries, continents, and cultures. The world is getting smaller. The globalization of clinical psychology has the potential to enhance well-being for each and every member of the human species.

Boston, MA, USA Stefan G. Hofmann

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Psychopathology and Classification

Sharon Eldar, Angelina F. Gómez, and Stefan G. Hofmann

Introduction

Psychopathology is a cognitive, emotional, behavioral or biological disorder within an individual that is associated with distress or impairment in functioning, and is not typical or culturally expected. A psychopathology, or mental disorder, is a multidimensional construct that depends on the individual's cultural and social context (Barlow, Durand, & Hofmann, 2016). The aim of this chapter is to give an overview of mental disorders as they are presently defined. We will first review the history of psychopathology, and how its classification has changed over the years. We will also discuss the cultural aspects involved in diagnosing psychopathology. Lastly, we will provide an overview of the main psychological disorders and culturally relevant aspects of their classification.

History of Psychopathology

Many unusual and strange behaviors used to be viewed as expressions of supernatural powers, such as evil spirits or the devil. This assumption caused people to turn to sorcery and violence to solve problematic behavior. In the fifteenth century the primary explanation of psychopathology turned from supernaturalism to theories of the moon's influence on the mind, as well as the removal of the "soul" from the body. Gradually, people began to agree on the existence of certain mental disorders, such as "hysteria." Unstable emotions began to be seen as consequences of these disorders, and systems of classification of disorders started to emerge. For example, the Swiss-German philosopher and physician, Paracelsus (1493–1541), is credited with starting the first

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system of classification. He distinguished four key groups of mental/behavioral disorders: *Lunatici*—reactions to phases of the moon; *Insani*—disorders present from birth or inherited from family; *Vesani*—disorders originating from consumption of contaminated food or drink; and *Melancholic*—poor temperament and ability to reason. The English scholar Robert Burton (1576–1640) extended this classification system, which separated madness (mania) from melancholy (see Millon & Simonesen, 2010).

During the eighteenth and nineteenth centuries, as clinics and hospitals began to record case histories and detailed observations of psychiatric patients, physicians began to identify syndromal groupings (i.e., clusters of symptoms) and classify them into disease entities. In addition, the growth of anatomical, physiological, and biochemical bodies of knowledge, as well as the nineteenth-century discoveries in bacterial and viral epidemiology, firmly established the disease concept of modern medicine, including the view of mental illness as a disease (Millon & Simonesen, 2010). As a result, thousands of people confined to dungeons of daily torture were released to asylums where medical forms of treatment began to be investigated.

Around the turn of the twentieth century, two new sources of inspiration contributed enormously to changes in the understanding and classification of psychopathology. The first was the German physician Emil Kraepelin (1856–1926), who is considered the founder of modern psychiatry. He hypothesized that specific symptom combinations occurring throughout the course of a psychiatric illness allowed for the identification of a particular mental disorder. He sought to bring order to symptom pictures and, most importantly, to patterns of onset, course, and outcome. Another major influence was Sigmund Freud (1856–1939). Freud's psychoanalytic approach to psychopathology was another major approach to understanding mental disorders. In contrast to Kraepelin's syndrome-based approach, Freud attempted to classify mental disorders based on etiology and specifically emphasized a person's early life experiences during childhood. Psychopathology was seen as a product of dysfunctional personality dynamics that evolving out of the manifold interactions between early life experiences, biological endowment, and intrapsychic conflicts (for review see Blatt & Luyten, 2010; Mitchell & Black, 2016). Psychoanalytic theory was the dominant approach to the classification and treatment of mental illness throughout the latter half of the nineteenth century and beginning of the twentieth century. Gradually, the new fields of behavioral and cognitive psychology began to use empirical methods to explore psychopathological constructs (as opposed to the case study approach favored by psychoanalytic or Neo-Freudian theorists). This movement brought along new definitions of mental disorders, considering symptoms of mental disorders as reflecting underlying dimensions (e.g., neuroticism), or discrete categories. However, regardless of whether mental disorders are considered dimensional or categorical, both approaches assume that symptoms reflect the presence of an underlying, unobserved, latent construct (e.g., Insel, 2014). This notion is currently being reconsidered. An alternative to the latent disease model is the *complex network* approach (Barabási, Gulbahce, & Loscalzo, 2011; Borsboom & Cramer, 2013; Hofmann, Curtiss, & McNally, 2016). Instead of assuming that symptoms arise from an underlying disease entity, this approach holds that disorders exist as systems of interrelated elements of a network. According to this view, emotional or behavioral

problems do not reflect an underlying latent disease that causes their emergence and co-occurrence. Instead, it is assumed that the network of the problems itself constitutes the disorder, and it is the interaction between these problems that give rise and maintain the disorder. For example, the complex network perspective does not assume that a stressful event activates an underlying entity called *depression*, which then causes the emergence of symptoms. Rather, it is assumed that stressful events activate certain problems (symptoms) that, in turn, activate other problems. Beyond studying the topography of a network, this approach might also be used to predict therapy outcome, relapse, and recovering by examining the network dynamics. Although highly promising, this approach will not be discussed in greater detail. Instead, we refer the reader to Hofmann et al. (2016).

Assessment of Psychopathology

Since the inception of psychopathological classification in the sixteenth century, different tools have been developed to determine whether a person's symptoms meet sufficient criteria to be characterized as a psychological disorder. Clinical assessment refers to the systematic evaluation and measurement of psychological, biological, and social factors in the individual. The process of clinical assessment and diagnosis are central to the study of psychopathology and, ultimately, to the treatment of psychological disorders.

The first systematic description of mental illness was not published until 1948, when the World Health Organization (WHO) added a section about mental health to its definition of health. Since then, many changes and developments have been made in this domain. Currently, the two predominant international diagnostic systems are the Diagnostic and Statistical Manual of Mental Disorders (DSM), first published in 1952 by the American Psychiatric Association (APA), and the WHO's chapter on mental disorders in the International Classification of Diseases and Related Health Problems (ICD). Both systems employ a categorical approach to classifying most psychiatric disorders, which ensures that researchers and clinicians around the world can make reliable and valid diagnoses. These diagnostic texts undergo revisions at irregular intervals, with the edition number appended to the title; to date, the most recent versions are the DSM-5, published in 2013, and the ICD-10, published in 1993.

The Diagnostic and Statistical Manual of Mental Disorders (DSM)

The publication of the first DSM (DSM-I) was motivated by increasing malcontent with the unstandardized and unreliable methods of assessment and diagnosis favored prior to the mid-twentieth century. Consequently, the APA formed the Committee on Nomenclature and Statistics, which set out to classify mental illnesses properly. The committee spit all psychiatric illnesses into three categories

based on the psychoanalytic approach: Psychoses, Neuroses, and Character disorders. These categories were named but not described further, as the committee believed vague definitions were more clinically useful (Blashfield, Flanagan, & Raley, 2010). The DSM-II, published in 1968, added short descriptions of each disorder, but still kept everything very vague. This version yielded low diagnostic reliability, and was not used in countries other than the United States. The publication of the DSM-III in 1980 constituted a major change in the nosology of mental disorders. Whereas the previous two versions were primarily psychoanalytic in nature, this version attempted to take an atheoretical approach to classification in order to be useful for clinicians with various theoretical viewpoints. Additionally, disorder categories were more scientifically defined and structured, which increased diagnostic reliability and validity. The DSM-III introduced the multiaxial system, which included five levels of influence on an individual's overall diagnostic picture: characteristics of the clinical disorder itself (Axis I), personality style and/or mental retardation (Axis II), relevant medical disorders (Axis III), environmental factors (Axis IV), and overall functional impairment (Axis V). This framework allowed clinicians to gather information about the individual's functioning in a number of areas, rather than limiting information to the disorder symptomatology. DSM-IV, published in 1994, changed many disorder criteria, as well as added many new features to each description, such as information related to race, gender, culture, expanded description of diagnostic features, and information on differential diagnosis. This version barely depended on expert consensus, relying instead on literature reviews and clinical trials to update and verify diagnostic criteria.

DSM-5. The most recent version of the DSM was the culmination of 14 years of research, preparation, and revision (La Roche, Fuentes, & Hinton, 2015). These revisions aimed to enhance clinical and research utility by providing concise diagnostic criteria for each disorder within a nosologically organized chapter framework, as well as supplementing these descriptions with dimensional measures that cross diagnostic boundaries, when appropriate. Additionally, this version includes a brief digest of information about the diagnosis, risk factors, associated features, research advances, and various expressions of the disorder (APA, 2013).

The most notable change in the DSM-5 was the removal of the multiaxial system. Axis I was combined with Axis II and III, so along with the primary disorder itself, clinicians can list as many medical conditions or personality disorder(s) as necessary. Axis IV, which covered psychosocial and environmental contributions to the disorder symptomology, was removed in order to better align with the ICD. The global assessment of functioning (GAF) scale previously included in Axis V was removed for reasons of insufficient conceptual clarity and clinical utility. In its place, the second version of the WHO Disability Assessment Schedule (WHODAS 2.0) is included in section III of DSM-5 (APA, 2013).

The reason for these conceptual and structural changes was the recognition that boundaries between disorders may be more porous than originally thought. Previous versions of the DSM considered each disorder as categorically separate from other diagnoses and health-related factors, and thus did not capture the widespread commonalities in symptoms and risk factors across many disorders, as has

been increasingly demonstrated in studies of comorbidity. Earlier editions of DSM prioritized avoiding false-positives by making diagnostic categories very narrow and specific, but critics argued that this approach did not fully capture the clinical reality of symptom heterogeneity within disorders. As such, much of the debate surrounding the development of the DSM-5 addressed this issue of categorical vs. dimensional classification. Despite the strong proponents of moving to a dimensional diagnostic system, the DSM-5 Task Force recognized that it is still premature to completely redefine most disorders. Thus, the "hybrid" organizational structure of the DSM-5 is meant to serve as a bridge to new diagnostic approaches without causing unnecessary disruption of current clinical practice and research (Kupfer, 2013; Stein et al., 2010).

As part of its nosological reorganization, chapters in the DSM-5 are organized based on developmental and lifespan considerations. The Manual begins with diagnoses thought to reflect developmental processes manifested early in life (e.g., neurodevelopmental disorders, schizophrenia and other psychotic disorders), followed by diagnoses that more commonly onset in adolescence and young adulthood (e.g. bipolar, depressive, and anxiety disorders), and ends with diagnoses relevant to adulthood and later life (e.g., neurocognitive disorders). A similar approach is taken within each chapter, where possible. This organizational structure facilitates the comprehensive use of lifespan information as a way to assist in diagnostic decision-making. In addition to these changes, the DSM-5 included significant content revisions to the diagnostic criteria of many disorders; these changes range from relatively minor alterations, such as new time-duration or symptom-count requirements, to major redefinitions, such as the dimensional assessment of Alcohol Use Disorders and Autism Spectrum Disorders. For more details on the changes from DSM-IV-TR to DSM-5 see: http://www.dsm5.org/documents/changes%20from%20dsm-iv-tr%20to%20dsm-5.pdf.

International Classification of Diseases and Related Health Problems (ICD)

The history of psychiatric classification in the ICD contains many similarities to the developments seen in the DSM. The sixth edition of the ICD, published in 1948, was the first to include a description of mental health disorders. Nevertheless, it was not until the early 1960s that the Mental Health Program of the WHO became actively engaged in improving the diagnosis and classification of mental disorders. At that time, the WHO convened a series of meetings that actively involved experts from different psychiatric disciplines and schools of thought, and well as representatives from all parts of the world. This extensive consultation process yielded numerous proposals to improve the classification of mental disorders, many of which were used in drafting the eighth edition of the ICD. However, much like the DSM-II, this edition had little international influence due to its severe lack of diagnostic reliability.

The 1970s brought further interest in improving psychiatric classification worldwide. This growth was due to the expansion of international collaborative studies, the availability of new treatments, and the need to develop specific criteria for classification in order to improve diagnostic reliability. Drawing from empirical support provided by international research collaborations and scientific conferences, the ICD-10 contains a clear set of diagnostic criteria, as well as assessment instruments to reliably obtain these diagnoses.

The tenth edition (ICD-10, 1993) chapter on mental health was developed simultaneously to the DSM-IV, to make them as compatible as possible. Accordingly, this version classifies mental disorders using a criteria-based system, and also includes detailed descriptions of the symptomology and clinical picture. There are, however, still differences between the two manuals in a few key areas. First, certain definitions or descriptions differ slightly; for example, Schizophrenia and Schizoaffective Psychoses have different criteria, and a traumatic event is defined differently within the Trauma-related disorders. Second, some disorders in the DSM are completely absent from the ICD, such as Narcissistic Personality Disorder, or Bipolar II.

Another key distinction is the ICD-10 maintains a multiaxial system, similar to DSM-IV with which it was developed. This system allows for social/environmental, functional impairment, and somatic factors to be considered in tandem with the psychiatric criteria. Lastly, the ICD not only contains descriptions of mental disorders, but also all medical disorders or causes of death; due to this vast scope, each version of the ICD comprises several distinct editions. The edition with the classification of mental disorders is in the ICD-10, but was published in 1992 and is therefore rather behind the DSM in terms of recent updates. The ICD-11 editing and development process began in 2007, and is projected to finish in 2018. As in the previous edition, ICD-11 was developed concurrently with the DSM-5. In both new editions, the grouping of disorders was changed from being based primarily on common presenting symptoms, to an organizational system that reflects common underlying etiological factors (where possible). The current status of the ICD-11 can be viewed online at: http://apps.who.int/classifications/icd11/browse/l-m/en.

Culture and Psychopathology

The study of psychopathology has traditionally been a Western pursuit emphasizing an individual-centered medical model. This system is consistent with an *emic* approach, or research conducted from the perspective of the subject, though there has been increasing interest in employing an *etic* approach, or research from the perspective of an outside observer. In this approach, researchers attempt to identify the universal elements of psychopathology, whereas research from an emic perspective studies specific psychopathologies within a given culture. In each of these approaches, “culture” has often been poorly or inconsistently defined. It is insufficient to define culture solely through proxy and broadly defined variables such as skin color (i.e., race) or place of birth (i.e., ethnicity). It is necessary to take into account the ways in which people

construct different cultural meanings, which are a result of a multiplicity of causes including religion, socioeconomic factors, and so forth. Culture refers to systems of knowledge, concepts, rules, and practices that are learned and transmitted across generations. This includes language, religion and spirituality, family structures, life-cycle stages, ceremonial rituals, and customs, as well as moral and legal systems (Schwartz, Unger, Zamboanga, & Szapocznik, 2010).

Prior to the DSM-5, critics using a cultural framework (e.g., La Roche, 2013; Sue & Sue, 2008) argued that the DSM's nosological system is based on Western American beliefs (e.g., individualism, emphasis on biology) and practices (e.g., standardization), which limits the system's usefulness among different cultural groups. More specifically, when Western American standards are used to diagnose cultural minorities it is more likely that culturally based factors will be misconstrued or overlooked (Hinton & Good, 2009; La Roche, 2013). This insufficient attention to cultural aspects is primarily a function of the DSM's emphasis on standard diagnostic criteria that can clearly define homogenous mental disorders. In addition, cultural differences and influences on psychopathology can be hard to articulate, and are even considered by some to be "superficial" characteristics next to biological considerations of disease etiology and maintenance. Moreover, research on cultural topics is not typically prioritized among American researchers, and is usually published in small journals—though this trend is slowly changing as research pursuits become increasingly global.

A cultural perspective on the study of psychopathology is important for several reasons. First, it may help in the development of culture-specific therapies. Second, it may provide valuable information about the psychological problems seen in particular cultures and their development as a function of the particular demands that culture places on individuals. Third, the examination of culture-specific syndromes, which are interesting in and of themselves, may help illuminate more general patterns of cultural values as they relate to the classification of mental disorders. Lastly, and most importantly, understanding the cultural context of mental disorders is essential for effective diagnostic assessment, clinical management, and treatment. Mental disorders should be defined in relation to cultural, social, and familial norms or values, particularly when defining "clinically significant impairment," as this subjective criterion can be heavily influenced by cultural norms. Culture provides an interpretive framework that shapes the experience and expression of the symptoms, signs, and behaviors that make up diagnostic criteria. Although some forms of psychopathological expression can be universal, cultural aspects can affect the manifestation of certain symptoms, and consequently the prevalence of mental disorders (Alegria et al., 2004). The boundaries between normality and pathology vary across cultures for specific types of behaviors. Thresholds of tolerance for specific symptoms or behaviors differ across cultures, social settings, and families. Hence, the level at which an experience becomes problematic or pathological will differ (APA, 2013). For example, all human beings will likely experience low moods, but cultural factors are important in defining what is considered "low," what terms are used to express these moods, when and how they are recognized as pathological, and how or from whom help is sought (Bhugra, 2009).

Diagnostic assessment must therefore consider whether an individual's experiences, symptoms, and behaviors differ from sociocultural norms and lead to difficulties in adaptation in the cultures of origin and in specific social or familial contexts. Accordingly, key cultural aspects relevant to diagnostic classification and assessment were considered in the development of the DSM-5. These considerations prompted the inclusion of a new "glossary of cultural concepts of distress," which describe several culture-specific syndromes, such as: Ataque de nervios (an emotional upset, including anxiety, anger, or grief among Latinos), Dhat syndrome (South Asian cultural explanation for semen loss in young men), or Taijin kyofusho (Japanese anxiety and avoidance of social interactions because of a fear of acting inadequate or offensive to others). Furthermore, the DSM-5 presents a Cultural Formulation Interview (CFI) in its appendices. This 16-item semi-structured interview is an assessment tool aimed at more accurately identifying components of an individual's cultural background that might impact their clinical presentation and care. The CFI directly assess an individual's beliefs, as well as define idioms of distress, rather than simply categorizing individuals as "multicultural" based on their skin color or place of birth. The information provided throughout the CFI can help practitioners avoid misdiagnosis, obtain clinically useful information, improve clinical rapport and therapeutic efficacy, guide research, and clarify cultural epidemiology.

Overview of Psychopathologies

In the next sections we will briefly describe a number of psychopathological categories and disorders contained in the DSM-5 and ICD-10. We will limit our discussion to some of the most common disorders.

Mood Disorders

Mood disorders describe a serious disturbance in mood, and are usually divided into depressive disorders and bipolar-related disorders. The ICD-10 groups these disorders under the same category, but the DSM-5 separated them, placing the bipolar-related disorders after the psychotic disorders chapter, and before the depressive disorders chapter. This change was the result of increasing evidence suggesting that bipolar disorders are etiologically similar to both diagnostic classes in terms of symptomatology, family history, and genetics (APA, 2013).

Depression is one of the most common mental disorders. The World Health Organization (WHO, 2016) estimated that depression affects 350 million people in the world. It is the leading cause of disability in the U.S and the world for people between ages 15 and 44, and 80% of people with depression are limited in their daily functioning, particular at work. The depressive disorders include Major Depressive Disorder (MDD), Persistent Depressive Disorder (previously dysthymia),

and Disruptive Mood Dysregulation Disorder (DMDD). The common feature of all depressive disorders is the presence of sad, empty, or irritable mood, accompanied by somatic and cognitive changes that significantly affect the individual's capacity to function. People with depression may experience a lack of interest and pleasure in daily activities, significant weight loss or gain, insomnia or excessive sleeping, lack of energy, inability to concentrate, feelings of worthlessness or excessive guilt and recurrent thoughts of death or suicide. The depressive disorders are differentiated by their symptom course, age of onset, or presumed etiology (APA, 2013; Leahy, Holland, & McGinn, 2012).

Bipolar related disorders are a cluster of disorders in which common emotions become magnified in intense and often unpredictable ways. Individuals with bipolar disorder can quickly swing from extremes of happiness, energy and clarity to sadness, fatigue and confusion. These shifts can be so devastating that individuals may choose suicide. The diagnosis of a bipolar disorder requires the experience of at least one manic episode, which describes a period of abnormally elevated or irritable mood resulting in over-activity, pressured speech, and decreased need for sleep. Bipolar disorders can also include episodes of depression, though not all people with mania become depressed. The ICD-10 also includes a diagnosis of Hypomania, which includes the same symptoms as a manic episode with two important differences: the mood disturbance is not severe enough to cause hospitalization or great functional impairment, and the episode does not include psychotic features. Bipolar disorders, in their various forms, affect 3.4% of the world's population, but the prevalence differs by country. For example, Merikangas et al. (2011) found that the United States has the highest lifetime and 12-month prevalence of bipolar disorders (4.4% and 2.8%, respectively), while India has the lowest (both 0.1%).

These cultural differences are also manifested in the variety of symptoms related to depression and bipolar disorders. For example, while depression has a core set of symptoms, (including low mood, sleep problems, lack of interest and energy, and poor concentration), other symptoms, such as shame and guilt, psychomotor retardation, low self-esteem and low self-confidence are more likely to vary across cultures. Similarly, in hypomania, over activity, sexual disinhibition and irritability are most likely universal, but behaviors such as over-spending may differ across ethnic and cultural groups (Bhugra, 2009). The main mood disorders are described in Table 1.

Anxiety Disorders

Anxiety Disorders are characterized by excessive worry about some feared outcome, which is disproportionate with the actual risk of that outcome, persists past the point where such anxious attention might be adaptive, and causes clinically significant distress, functional impairment, or avoidance. Within the anxiety disorders fall more specific diagnoses, including general anxiety, social anxiety, and panic disorder. The core feature of all anxiety disorders is worry, but the object of worry and the typical behavioral response patterns differ slightly for each disorder.

Table 1 Description of mood disorders

Disorder	Description
Major depression disorder (MDD)	Sad mood or loss of interest or pleasure, accompanied by other symptoms such as sleep problems, weight loss/gain, psychomotor agitation/retardation, and lack of energy; symptoms are present for most of the day, nearly every day, for at least 2 weeks
Persistent depressive disorder (dysthymia)	Depressed mood that occurs more days than not for most of the day, lasting for at least 2 years. This mood is accompanied by other symptoms described in MDD
Disruptive mood dysregulation disorder	Presentation of children (up to 12 years of age) with persistent irritability and frequent episodes of uncontrolled extreme behavior and temperamental outbursts
Bipolar I	At least one full manic episode; the occurrence of a major depressive episode may follow, but is not required for a diagnosis
Bipolar II	A hypomanic episode diagnosed after one or more major depressive episode
Cyclothymia	A chronic (at least 2 years) fluctuating mood disturbance, involving numerous distinct periods of hypomania and depression

Anxiety disorders are some of the most prevalent disorders, affecting three out of ten people in their lifetime (Kessler et al., 2005). They tend to be chronic, start early in life (Martin, 2003), and comorbid with other mental illnesses (Michael, Zetsche, & Margraf, 2007). The most common anxiety disorders are described below, and brief descriptions of all anxiety disorders can be found in Table 2.

As far as research has explored, general anxiety disorder appears in most cultures; however, there is a great degree of variation in the expression of anxiety between cultures. More specifically, anxiety is manifested in primarily somatic symptoms in some cultures, but takes a more cognitive focus among others. Additionally, the content and severity of worry tends to be culture-specific, so a diagnosis of general anxiety disorder must be made within the context of what the individual's society views to be worrisome and excessive (Marques, Robinaugh, LeBlanc, & Hinton, 2011).

Generalized Anxiety Disorder (GAD) describes a pattern of excessive worry that occurs most days for at least 6 months; this worry is hard to control, causes clinically significant distress or functional impairment, and is associated with three or more psychosomatic symptoms of distress, including: restlessness, fatigue, difficulty concentrating, irritability, muscle tension, or sleep disturbance (APA, 2013). Whereas normative anxiety waxes and wanes, general anxiety disorder tends to persist throughout a person's life, and rates of full remission are very low (Rodriguez et al., 2006). The 12-month prevalence of general anxiety disorder is estimated around 18% of the world's adult population (Kessler, Chiu, Demler, & Walters, 2005). Generalized anxiety disorder is present in both males and females, though the disorder is much more common among females (Yonkers, Warshaw, Massion, & Keller, 1996).

Social anxiety disorder (SAD, formerly social phobia). In SAD the content of the worry is specific to social situations in which the individual is potentially exposed to scrutiny or negative evaluation. These situations could include real evaluative

Table 2 Description of anxiety disorders

Disorder	Description
Separation anxiety disorder	Developmentally inappropriate and excessive anxiety surrounding separation from attachment figures, lasting at least 4 weeks in children, or 6 months in adults
Selective mutism	Consistent failure to speak in specific social situations, despite speaking in other situations; disturbance lasts at least 1 month and interferes with education or occupational achievement, or social communication
Specific phobia	Marked fear of a specific object or situation (e.g. flying, heights, animals, injections), which is disproportionate to the actual threat of harm, causes functional impairment or distress, and lasts for at least 6 months
Social anxiety disorder (SAD, formerly social phobia)	Excessive worry about negative evaluation in social situations, lasting for at least 6 months and causing significant distress, impairment, or avoidance behaviors
Panic disorder	Experience of at least one panic attack, followed by at least 1 month of excessive worry about having another panic attack, or intolerance of panic symptoms
Agoraphobia	Fear of being public places from which escape might be difficult; fears and behavioral avoidance last at least 6 months and cause significant distress or impairment
General anxiety disorder (GAD)	Excessive and pervasive worry about issues of daily life, associated with persistent psychosomatic symptoms of worry; symptoms last for at least 6 months, and cause clinically significant distress, avoidance behaviors, and/or functional impairment

circumstances, such as giving a presentation or going on a date, but could also be casual social settings such as going to dinner with friends. Regardless of the circumstance, the individual with social anxiety experiences a degree of fear that is disproportionate to the actual risk of being negatively evaluated or the consequences of such an evaluation; this fear is frequently so intense that the person will completely avoid the situation, or will endure it with debilitating anxiety. Social anxiety disorder tends to onset earlier in life; 50% of cases onset by 11 years of age, and 80% by the age of 20 (Stein & Stein, 2008). Community estimates of rates of remission vary widely, but the average remission rate based on prospective studies is estimated to be around 50% (Vriends, Bolt, & Kunz, 2014).

In East Asian cultures such as Japan and Korea, the syndrome of *taijin kyofusho* is very similar to social anxiety disorder, as it is characterized by a fear of social evaluation associated with the concern that the individual makes other people uncomfortable (Kleinknecht, Dinnel, Kleinknecht, Hiruma, & Harada, 1997). Additionally, the prevalence of social anxiety disorder may not accurately reflect the prevalence of social anxiety symptoms; for example, Asian cultures typically have the lowest rates of the disorder, but individuals in these cultures still clearly experience symptoms of social anxiety. This discrepancy perhaps reflects different perceptions of what constitutes "excessive" or "pathological" social anxiety, and thus

it is essential to consider an individual's cultural context when making a diagnosis (Hofmann, Asnaani, & Hinton, 2010).

Panic Disorder. Panic Disorder differs from general and social anxiety disorder inasmuch as the primary object of anxiety is the experience of anxiety itself; more specifically, individuals with panic disorder have experienced at least one panic attack, which then leads to excessive worry about having another panic attack, or the consequences of such panic symptoms (e.g. worry about being "crazy" or having a stroke). Additionally, this subsequent concern can be manifested in significant and maladaptive behavioral changes related to the fear of having an attack, such as avoidance of unfamiliar situations or cardiovascular exercise.

Obsessive-Compulsive Spectrum Disorders

In previous versions of the DSM, OCD was classified under the Anxiety Disorders. However, the DSM-5 created a new chapter on Obsessive Compulsive and Related Disorders, which in addition to OCD includes body dysmorphic disorder (BDD), hoarding disorder, trichotillomania (hair-pulling disorder), and excoriation (skin-picking) disorder (Stein, Craske, Friedman, & Phillips, 2014). The inclusion of this new chapter reflects the gathering empirical evidence that these disorders share diagnostic characteristics, as well as etiological pathways (Monzani, Rijsdijk, Harris, & Mataix-Cols, 2014). All of the obsessive-compulsive spectrum disorders are characterized by preoccupations, repetitive behaviors or mental acts in response to those preoccupations, the excessive or developmentally atypical persistence of symptoms, and clinically significant functional impairment or distress (APA, 2013). The following includes a description of OCD, and a brief review of the OC spectrum disorders is presented in Table 3.

Obsessive compulsive disorder (OCD) is a debilitating psychiatric disorder consisting of persistent intrusive thoughts or images, and/or compulsory behaviors that cause significant distress and anxiety. OCD affects approximately 2% of the population, and commonly emerges in childhood and adolescence. As a clinically heterogeneous disorder, individuals with OCD may present with a variety of symptom profiles. *Obsessions* are recurrent thoughts, urges, or images that are unwanted, yet repetitively intrude into an individual's mind and cause anxiety and distress. The individual will often ignore or suppress these obsessions, or will attempt to neutralize them with another thought or action. Such a neutralizing thought or action is considered a *compulsion*, defined as any behavior or mental act that the individual feels driven to perform in order to prevent or reduce anxiety or distress associated with an obsession (e.g. cleaning, arranging, checking, or praying). While repetitive or ritualized behaviors are common among the general population and can even be quite useful (e.g. organizational aids or personal hygiene rituals), the symptoms of OCD are much more extreme, and cause varying degrees of impairment across any or all domains of life, including personal, social, occupational, and even medical health.

Table 3 Description of obsessive-compulsive spectrum disorders

Disorder	Description
Obsessive-compulsive disorder (OCD)	Presence of obsessions, compulsions, or both, which occupy at least 1 h/day or cause significant distress or impairment
Body dysmorphic disorder (BDD)	Preoccupation with one or more perceived defects or flaws in physical appearance, associated with repetitive behaviors or mental acts, and which cause distress or impairment
Hoarding disorder (HD)	Persistent difficulty discarding possessions, regardless of their actual value, which results in compromised living areas and causes distress or impairment
Trichotillomania (hair-pulling disorder)	Recurrent hair-pulling resulting in hair loss and significant distress or impairment
Excoriation (skin-picking) disorder	Recurrent skin-picking resulting in skin lesions and significant distress or impairment

Obsessions and compulsions can also be time-consuming, and even if an individual reports no distress or impairment, a diagnosis of OCD may still be given if the symptoms occupy more than an hour each day (Gómez, Cooperman, & Geller, 2015).

Trauma and Stressor Related Disorders (Including Dissociative Disorder)

Similar to the obsessive-compulsive disorders chapter, the chapter on trauma- and stressor-related disorders is new to the DSM-5. This chapter includes disorders in which exposure to a traumatic or stressful event is listed explicitly as a diagnostic criterion. In DSM-IV, post-traumatic stress disorder (PTSD) and acute stress disorder were under the umbrella of anxiety disorders, but a distinct chapter was warranted for a few reasons. First, trauma-related disorders differ from anxiety disorders in the variety of commonly elicited emotions (e.g. guilt, rage and shame, not only anxiety and fear-based symptoms); second, they all share a proximal instigating stressful event followed by intense emotional responses, whereas anxiety disorders are not typically caused by one triggering event; lastly, the ICD-10 has long distinguished trauma-related disorders from anxiety disorders (Möller et al., 2015). The trauma and stressor-related disorders include PTSD, acute stress disorder, reactive attachment disorder, disinhibited social engagement disorder, and adjustment disorders, each of which will be briefly described.

PTSD is a well-recognized psychiatric disorder that occurs following a major traumatic event. The event must be an exposure or repeated exposures to actual or threatened death, serious injury, or sexual violence, which the individual experienced or witnessed while it was happening. A diagnosis of PTSD may also be given if the person learned about (but did not witness) an event that happened to a close relative, but only if the event was violent or accidental. The characteristic symptoms of PTSD include re-experiencing phenomena (such as nightmares or recurrent distressing thoughts or

intrusive images of the event), avoidance and numbing of general responsiveness (such as trying not to talk about or be reminded of the traumatic event), feelings of detachment or estrangement from other people, and symptoms of hyperarousal, including sleep disturbance, increased irritability and hypervigilance (Bisson & Andrew, 2007). In order to be diagnosed with PTSD all of these symptoms need to be present for more than a month.

PTSD is more prevalent among females than among males across the lifespan, and lifetime risk for PTSD using DSM-IV criteria is 8.7% (Kessler, Berglund, et al., 2005). The risk of onset and severity of PTSD may differ across cultural groups as a result of variation in the type of traumatic exposure. The diagnostic criteria for PTSD are valid cross-culturally, in that they constitute a cohering group of symptoms that occur in diverse cultural settings in response to trauma. However, there are some differences in symptoms expression across cultural, such as the salience of avoidance and somatic symptoms, and the importance of distressing dreams (Hinton & Lewis-Fernandez, 2011).

Acute stress disorder has a similar symptom profile as PTSD, but a shorter time-requirement, as symptoms can last for 3 days to 1 month following exposure to one or more traumatic events (Bryant, Friedman, Spiegel, Ursano, & Strain, 2011). Similarly, a diagnosis of adjustment disorder applies to milder reactions to a stressful life event, which nevertheless cause significant distress and impairment at least 3 months following the stressor. The ICD-10 emphasizes that the adjustment disorder diagnosis should be given following a stressor that is not unusual or catastrophic, such as a move or transition to a new job.

Dissociative disorders. These disorders are also part of the trauma- and stressor-related category in the ICD-10, although they have their own category in the DSM-5. Dissociative disorders are characterized by a disruption of and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control, and behavior. The dissociative disorders are frequently found in the aftermath of trauma, and many of the symptoms are influenced by the proximity to trauma (Wolf et al., 2012).

There are a few stress-related disorders that typically occur in childhood; the DSM-5 places these disorders in the stressor-related chapter, whereas the ICD-10 classifies these disorders under the age-related or developmental disorders category. *Reactive attachment disorder* is defined as a pattern of markedly disturbed and developmentally inappropriate attachment behaviors in response to early childhood stressors or severe neglect. Developmentally inappropriate attachment behaviors include rarely or minimally turning to an attachment figure (i.e. parent or primary caregiver) for comfort, support, protection, and nurturance (Zeanah, Chesher, & Boris, 2016). *Disinhibited social engagement disorder* is a pattern of behavior in which the child shows no inhibitions when approaching adults, and this overly familiar behavior violates the social boundaries of the culture. In order to get the diagnosis, the child must be at least 9 months old, the age at which they are developmentally able to form selective attachments (Lehmann, Breivik, Heiervang, Havik, & Havik, 2016).

Substance-Related and Addictive Disorder

The substance-related disorders encompass eight to ten separate classes of drugs: alcohol; caffeine; cannabis; hallucinogens (with separate categories for phencyclidine and other hallucinogens); inhalants; opioids; sedatives, hypnotics, and anxiolytics; stimulants (amphetamine-type substances, cocaine, and other stimulants); tobacco; and other (or unknown) substances. The pharmacological mechanisms by which each class of drugs activates reward systems in the brain are different, but all produce feelings of pleasure (Volkow, Koob, & McLellan, 2016). In addition to the substance-related disorders, this category of disorders also includes gambling disorder, reflecting evidence that gambling behaviors activate reward systems similar to those activated by drugs of abuse, as well as produce some behavioral symptoms that appear comparable to those produced by the substance use disorders (Romanczuk-Seiferth, van den Brink, & Goudriaan, 2014).

Across the substance classes, the DSM-5 classifies two types of disorders, and the ICD-10 also includes similar classifications, but in a slightly different format. One is the Substance-Use Disorder (DSM-5) or Dependence Syndrome (ICD-10). This disorder-type refers to a problematic pattern of use, which leads to clinically significant impairment or distress. Unlike many other disorders, this "functional impairment" criterion contains more specific descriptions of possible manifestations. For example, consumption of a larger amount of the substance over a longer period than was originally intended; a persistent desire or unsuccessful efforts to control or curb use; marked craving for the substance; continued use despite social or interpersonal problems as a result of substance-use, etc. The DSM-5 includes a list of 11 symptoms, and the number of symptoms endorsed by the individual defines the severity of the disorder. Critics of this approach claim that the individual's history of use and other emotional experiences may be more informative and predictive of future impairment than simply counting symptoms (Lima et al., 2015). The fact that the ICD-10 includes fewer symptoms than the DSM-5 reinforces this critique, and creates differences between the two diagnostic systems (Möller et al., 2015).

The second disorder-type in the substance use category is the induced disorders, which include intoxication, withdrawal, and other substance/medication-induced mental disorders (e.g., substance-induced psychotic disorder, substance-induced depressive disorder). Intoxication disorders (e.g. opioid intoxication; sedative, hypnotic or anxiolytic intoxication) are clinically significant problematic behavioral or psychological changes that developed during, or shortly after, the use of a substance. For a person to become intoxicated depends on which drug is taken, how much is ingested, and the person's individual biological reaction. Symptoms of intoxication differ across substance classes, and usually include impaired judgment, mood changes, and lowered motor ability. Withdrawal disorders (e.g. stimulant withdrawal; caffeine withdrawal) are characterized by physiological and psychological symptoms, such as changes in mood, sleep, and appetite dysregulation, which develop shortly after cessation or reduction of substance consumption, and which cause significant distress or impairment (Starcevic, 2016).

Somatic Disorders

Somatic disorders are broadly characterized by anxiety or distress related to the experience of physical symptoms such as pain or fatigue (Dimsdale et al., 2013). This category includes two main disorder-types, which have different names and slightly different criteria in the DSM and the ICD. The first disorder-type includes Somatic Symptom Disorder (DSM-5), or Somatization Disorder (ICD-10), which describe psychological distress that is associated with, and compounds the severity of, physical symptoms such as pain; the other disorder-type includes Illness Anxiety (DSM-5), or Hypochondriacal Disorder (ICD-10), which describe a persistent preoccupation and anxiety that is focused on the possibility of having or developing a serious disease.

Somatic disorders are among the most frequent reasons for doctor visits, and are present in 10–20% of primary care patients (Sharma & Manjula, 2013). Consequently, somatic disorders are associated with public health costs that are comparable to those caused by anxiety and depressive disorders (Konnopka et al., 2012; Kroenke, 2007; Steinbrecher, Koerber, Frieser, & Hiller, 2011). Additionally, the functional impairment associated with somatoform disorders is comparable to that seen in depressive and anxiety disorders. Somatic disorders may also accompany other psychiatric disorders, especially depression and anxiety, and the complexity introduced by this dual diagnosis often results in higher severity, functional impairment, and even refractoriness to traditional anxiety or depression treatments (Katz, Rosenbloom, & Fashler, 2015).

The DSM-5 and the ICD-10 define somatic disorders differently, but a common feature is the association between physiological symptoms and significant distress or impairment. The main difference lies in how each set of diagnostic criteria handle the occurrence of true somatic symptoms. In the ICD-10 (as well as in the DSM-IV), diagnostic criteria specify that the individual's physical symptoms cannot be explained by any detectable physical condition. However, in the DSM-5 a diagnosis is made on the basis of distressing somatic symptoms plus abnormal thoughts, feelings, and behaviors in response to these symptoms, rather than the absence of a medical explanation for somatic symptoms. The notion behind this change is that incorporating affective, cognitive, and behavioral components into the criteria provides a more comprehensive and accurate reflection of the true clinical picture than can be achieved by assessing the somatic complaints alone (APA, 2013).

Research on cultural factors involved in somatic disorders indicates that somatization—in all of its various definitions—is common among all cultural groups and societies. Differences among groups may reflect cultural styles of expressing distress that are influenced not only by cultural beliefs and practices, but also by familiarity with health care systems and pathways to care (Kirmayer & Young, 1998).

Feeding and Eating Disorders

Feeding and eating disorders are characterized by a persistent disturbance of eating or eating-related behavior that results in the altered consumption or absorption of food, and which significantly impairs physical health or psychosocial functioning (APA, 2013). Feeding and eating disorders are associated with increased psychopathology, health problems, and impairment in quality of life (Hilbert, de Zwaan, & Braehler, 2012).

Diagnostic criteria are provided for pica, rumination disorder, avoidant/restrictive food intake disorder, anorexia nervosa, bulimia nervosa, and binge-eating disorder, and are presented in Table 4. The more prevalent disorders are anorexia nervosa (0.3%), bulimia nervosa (0.9%), and binge-eating disorder (1.6%) (Swanson, Crow, Le Grange, Swendsen, & Merikangas, 2011). Eating disorders are rare in the general population, but are more common among adolescent girls and young women; nevertheless, they can affect both women and men of different ages and baseline weights (Hilbert et al., 2012; Hoek & van Hoeken, 2003).

Between 1960 and 2000, the frequency of eating disorders increased dramatically among Western countries, which emphasizes the strong influence of cultural factors on the development and maintenance of eating disorders (Lindvall Dahlgren & Wisting, 2016). To this day, the etiology of eating disorders seems to be more sociocultural than psychological or biological, as is the case for other disorders. This understanding is based on the low incidence of eating disorders among countries and cultures in which people are struggling to buy and find food. However, this pattern may be shifting, as there is evidence that eating disorders are emerging in Eastern cultures as well (Barlow et al., 2016).

Sleep-Wake Disorders

Sleep is essential for a person's health and wellbeing, though the amount sleep needed varies among individuals (Flueckiger, Lieb, Meyer, Witthauer, & Mata, 2016). In general, most healthy adults are built for 16 h of wakefulness and need an average of 8 h of sleep a night. Unfortunately, up to 60% of adults report experiencing sleep problems at least a few nights a week, due to different stressors, living and working style, and physiological conditions. The majority of individuals with these sleep problems go undiagnosed and untreated (Demir et al., 2015). In addition, more than 40% of adults experience daytime sleepiness severe enough to interfere with their daily activities at least a few days each month, with 20% reporting impairing sleepiness a few days a week or more. Groups that are particularly at risk for sleep deprivation include night shift workers, physicians, truck drivers, parents, and teenagers (APA, http://www.apa.org/topics/sleep/why.aspx). The prevalence of sleep-wake disorders depends on the type of disorder, and ranges from rare (e.g. narcolepsy, <1% of the population), to common (e.g. insomnia, 6–10%; breathing–related sleep disorders, 2–15%; rapid eye movement sleep behavior disorder, 10–30%) (Chung et al., 2015).

Table 4 Description of eating disorders

Disorder	Description
Pica	Persistent eating of nonnutritive, nonfood substances over a period of at least 1 month. The eating is inappropriate to the developmental level of the individual, and is not part of a culturally supported or socially normative practice
Rumination disorder	Repeated regurgitation of food over a period of at least 1 month. Regurgitated food may be re-chewed, re-swallowed, or spit out, and is not attributable to an associated gastrointestinal or other medical condition
Avoidant/restrictive food intake disorder	Avoidance or restriction of food intake, manifested by clinically significant failure to meet requirements for nutrition or insufficient energy intake through oral intake of food
Anorexia nervosa	An intense fear of gaining weight or of becoming fat, accompanied with significantly distorted body image. The individual maintains a body weight that is below a minimally normal level, but is nevertheless afraid of being fat. Gaining weight, or even failure to continually lose weight, can cause intense panic, anxiety and depression. Death most commonly results from medical complications associated with the disorder itself or from suicide
Bulimia nervosa	Recurrent episodes of binge eating and compensatory behavior, such as self-induced vomiting, strict dieting, or the misuse of laxatives. Binge-purge episodes must occur at least once per week for 3 months. Regular purging can be very destructive physiologically, and has the potential to cause permanent damage to functions, including endocrine, cardiovascular, and dental health. Individuals are typically ashamed of their eating problems and attempt to conceal their symptoms
Binge-eating disorder (BED)	Recurrent episodes of uncontrolled binge eating that must occur, on average, at least once per week for 3 months. Unlike bulimia nervosa, BED does not include compensatory purging behavior. Binge eating must be characterized by marked distress and at least three of the following features: Eating much more rapidly than normal; eating until feeling uncomfortably full; eating large amounts of food when not feeling physically hungry; eating alone because of feeling embarrassed by how much one is eating; and feeling disgusted with oneself, depressed, or very guilty afterward

Sleep-wake disorders encompass a broad range of clinical features. They are traditionally divided into two large categories: Dyssomnias and Parasomnias (Ohayon, 2005). Dyssomnias are sleep disorders characterized by abnormalities in the amount, quantity, or timing of sleep. As such, they are associated with difficulty initiating or maintaining sleep, as well as daytime sleepiness (Chung et al., 2015). This category includes insomnia disorder, hypersomnolence disorder, narcolepsy, breathing-related sleep disorders, and circadian rhythm sleep-wake disorders. Parasomnias cover abnormal behavioral or physiological events occurring during sleep, but not involving the sleep mechanisms per se. Under this category are the

non-rapid eye movement (NREM) sleep arousal disorders, nightmare disorder, rapid eye movement (REM) sleep behavior disorder, restless legs syndrome, and substance/medication-induced sleep disorder. Individuals with these disorders usually complain about daytime distress and impairment, depression, anxiety, and cognitive changes. Furthermore, persistent sleep disturbances (both insomnia and excessive sleepiness) are established risk factors for the subsequent development of mental illness and substance use disorders (APA, 2013). A summary of the sleep-wake disorders can be found in Table 5.

Sexual Dysfunctions, Paraphilic Disorders, and Gender Dysphoria

In terms of sexual disorders, it is hard to clearly differentiate normal sexual behavior from distorted or maladaptive sexual behavior. This difficulty stems from differences in behavior that is considered acceptable in different cultures, as well as from different genders. For example, Asian countries place a much higher value on feminine virginity, and social control over feminine sexuality is typically very strong. Conversely, among developed individualistic western countries such as the US, a higher degree of sexual activity, including premarital sex, is generally accepted (Ubillos, Paez, & González, 2000).

In terms of diagnosing sexual disorders, current views tend to be quite tolerant of a variety of sexual expression, unless the behavior is associated with substantial impairment in functioning or involves non-consenting individuals such as children (Barlow et al., 2016). Unlike the DSM-IV, in which the Sexual and Gender Identity Disorders constituted one stand-alone chapter, the DSM-5 and the ICD-10 have three separate chapters for Sexual Dysfunctions, Paraphilic Disorders/Disorders of Sexual Preference, and Gender Dysphoria/Gender Identity Disorder. Each category is briefly described, and the specific disorders are presented in Table 6.

Sexual Dysfunctions

Sexual dysfunctions are a heterogeneous group of disorders that are typically characterized by a clinically significant disturbance in a person's ability to respond sexually or to experience sexual pleasure. Research shows that the prevalence of people with sexual dysfunction can be as high as 45%, but only around 25% of these individuals expressed significant distress (Bancroft, Loftus, & Long, 2003), which is required for a diagnosis according to the DSM-5. Sexual dysfunctions occur among all genders and sexual orientations. This category includes: delayed ejaculation, erectile disorder, female orgasmic disorder, female sexual interest/arousal disorder, genito-pelvic pain/penetration disorder, male hypoactive sexual desire disorder,

Table 5 Description of sleep-wake disorders

Category	Disorder	Description
Dyssomnias Problems in the amount, timing or quality of sleep	**Insomnia disorder**	Difficulties falling and staying asleep, and not feeling rested, even after sleeping
	Hypersomnolence disorders	Excessive sleeping at night, or frequent falling asleep during the day
	Narcolepsy	Poor control of sleep-wake cycles. With periods of extreme daytime sleepiness and sudden, irresistible bouts of sleep
	Breathing-related sleep disorders	A variety of breathing problems that occur during sleep and that lead to hypersomnia or insomnia
	Circadian rhythm sleep-wake disorder	When sleep times are out of alignment, thus sleep times are not normal at night
Parasomnias Abnormal events that occur during sleep or just upon awakening	**Disorders of arousal**	Motor movements and behaviors that occur during sleep including incomplete awakening (confusional arousal), sleep walking, or sleep terrors (waking up with a panicky scream)
	Nightmare disorder	Frequently awakened with detailed and vivid recall of intensely frightening dreams, usually involving threats to survival, security or self-esteem
	Rapid eye movement sleep behavior disorder	Episodes of arousal during sleep in which the individual engages in activities associated with waking, without actually being awake (e.g. acting out dreams)
	Restless legs syndrome	A relatively common phenomenon that involves urges to move the legs as a result of unpleasant sensations
	Substance-induced sleep disorder	Sleep disturbance that is the result of substance use

premature ejaculation, substance/medication-induced sexual dysfunction, and other specified or unspecified sexual dysfunction. An individual may have several sexual dysfunctions at the same time (Balon, Segraves, & Clayton, 2007).

Sexual dysfunctions are interdependent with psychosocial and biological/physiological factors, and diagnosis should include a careful consideration of issues such as the partner's emotional or personality problems, quality of the relationship, individual vulnerability, cultural or religious attitudes toward sexuality, and medical factors relevant to prognosis, course, or treatment.

Paraphilic Disorders/Disorders of Sexual Preference

Paraphilia means strong attraction to abnormal stimuli. Paraphilic disorders are diagnosed when sexual arousal occurs primarily in the context of inappropriate or atypical objects or individuals, and is associated with distress and impairment, or harm to others. The DSM-5 section on paraphilic/sexual disorders includes the most common disorders, as well as those classified as criminal offenses, and are organized into two groups of disorders. The first is based on anomalous activity preferences. These disorders are subdivided into courtship disorders, which resemble distorted components of human courtship behavior (voyeuristic disorder, exhibitionistic disorder, and frotteuristic disorder), and algolagnic disorders, which involve deriving sexual pleasure from physical pain (sexual masochism disorder and sexual sadism disorder). The second group of disorders is based on anomalous sexual target preferences. These disorders include one directed at other humans (pedophilic disorder), and two directed elsewhere (fetishistic disorder and transvestic disorder). It is important to note that for all these disorders, the presence of a paraphilia does not itself justify a diagnosis, but must also be accompanied by clinically significant distress, functional impairment, or harm to non-consenting others.

The population prevalence of most of these disorders is unknown, and estimates vary widely from 2 to 30% across disorders. Usually the prevalence among males is higher than in females (Konrad, Welke, & Opitz-Welke, 2015).

Table 6 Description of sexual dysfunctions, paraphilic disorders, and gender dysphoria

Category	Disorder	Description
Sexual dysfunctions	Delayed ejaculation	Marked delay, infrequency, or absence of ejaculation
	Erectile disorder	Marked difficulty in obtaining or maintaining an erection or decrease in erectile rigidity
	Female orgasmic disorder	Delay, infrequency, absence, or reduction in experiencing orgasm
	Female sexual interest/arousal disorder	Lack of, or significantly reduced, sexual interest or arousal
	Genito-pelvic pain/penetration disorder	Difficulties, pain, tension, or anxiety related to vaginal penetration
	Male hypoactive sexual desire disorder	Deficient or absent sexual/erotic thoughts, fantasies, or desire for sexual activity
	Premature (early) ejaculation	Pattern of ejaculation occurring very early during sexual activity and before the individual wishes it
	Substance/medication-induced sexual dysfunction	A clinically significant disturbance in sexual function caused by exposure to a substance or medication

(continued)

Table 6 (continued)

Category	Disorder	Description
Paraphilic disorders	Voyeuristic	Recurrent and intense sexual arousal from observing an unsuspecting person who is naked, in the process of disrobing, or engaging in sexual activity
	Exhibitionistic disorder	Recurrent and intense sexual arousal from the exposure of one's genitals to an unsuspecting person
	Frotteuristic disorder	Recurrent and intense sexual arousal from touching or rubbing against a non-consenting person
	Sexual masochism disorder	Recurrent and intense sexual arousal from the act of being humiliated, beaten, bound, or otherwise made to suffer
	Sexual sadism disorder	Recurrent and intense sexual arousal from the physical or psychological suffering of another person
	Pedophilic disorder	Intense sexually arousing fantasies, sexual urges, or behaviors involving sexual activity with a prepubescent child (generally age 13 years or younger)
	Fetishistic disorder	Recurrent and intense sexual arousal from either the use of nonliving objects or a highly specific focus on non-genital body part(s)
	Transvestic disorder	Recurrent and intense sexual arousal from wearing clothes typical of the opposite sex
Gender dysphoria	Under this category are gender dysphoria; other specified gender dysphoria; unspecified gender dysphoria	A marked incongruence between one's experienced/expressed gender and assigned/biological sex

Gender Dysphoria/Gender Identity Disorder

Gender dysphoria refers to cases where a person's biological sex is not consistent with what they experience as their correct gender. The diagnosis is given when this inconsistency is associated with clinically significant distress or impairment. Individuals with this disorder often feel trapped in a body of the wrong sex, and wish to live life openly in a manner consistent with that of their self-identified gender. The prevalence of gender dysphoria ranges from 0.002 to 0.014% (Dhejne, Öberg, Arver, & Landén, 2014).

Expression of gender dysphoria varies with age. Young children are less likely than older children, adolescents, and adults to express extreme and persistent

anatomic dysphoria. In adolescents and adults, incongruence between experienced gender and somatic sex is a central feature of the diagnosis. Factors related to distress and impairment also vary with age. A very young child may show signs of distress (e.g., intense crying) only in specific situations in which they are reminded of their divergent gender identification. In adolescents and adults, distress may manifest because of strong incongruence between experienced gender and somatic sex. Such distress may, however, be mitigated by supportive environments and knowledge that biomedical treatments exist to reduce incongruence (APA, 2013).

Disruptive, Impulse-Control and Conduct Disorders

Under this category are disorders involving problems in the self-control of emotions and behaviors. In the ICD-10, most of these disorders fall under the same category as personality disorders, though some are in the developmental disorders section. The disruptive behavior disorders are manifested in behaviors and habits that violate the rights of others (e.g., aggression, destruction of property) and/or that bring the individual into significant conflict with societal norms or authority figures. Since some of these behaviors can occur to some degree in typically developing individuals, the diagnosing clinician must consider the frequency and pervasiveness of behaviors across multiple contexts, the impairment associated with these behaviors. Furthermore, it is particularly important that behaviors be assessed relative to what is normative for a person's age, gender, and culture. These disorders tend to be more common in males than in females, and to onset in childhood or adolescence.

Oppositional defiant disorder. Defined as a frequent and persistent pattern of angry/irritable mood (e.g. losing temper), argumentative/defiant behavior (e.g. blaming others for their mistakes), or vindictiveness. The disturbance in behavior is associated with distress in the individual or others that are close to them.

Intermittent explosive disorder. Describes a pattern of poorly controlled emotions and verbal or physical outbursts of anger towards property, animals or other individuals. These behaviors are disproportionate to the interpersonal or other provocation, or to other psychosocial stressors.

Conduct disorder. Focuses largely on poorly controlled behaviors that violate the rights of others or that violate major societal norms (e.g. bullying others, initiating physical fights, being cruel, etc.). Conduct disorder is one of the few disorders to include in its criteria specific legal or social offenses (e.g. larceny, truancy).

Pyromania and kleptomania. Less common diagnoses characterized by poor impulse control related to specific behaviors (fire setting and stealing, respectively) that relieve internal tension.

Schizophrenia Spectrum and Other Psychotic Disorders

Schizophrenia is a complex syndrome affecting 1% of the population, irrespective of culture, class or race. The first episode of schizophrenia often occurs when a person is in their late adolescence or early adulthood and the course of the illness is variable. Some signs of the development of the disorder may be visible in childhood. This disorder can disrupt a person's perception, thought, speech, and movement and hence has a devastating effect on the individual and their family members. The prognosis of schizophrenia is poor, and recovery is very rare.

The symptoms of schizophrenia are varied, and can manifest differently among individuals. Some people have difficulties with their thoughts, making illogical associations and developing false and sometimes bizarre explanations (i.e., delusions) for their experiences or symptoms. Problems with false perceptions may also occur, for example hearing voices or seeing visions (i.e., hallucinations). Difficulties with concentration, attention and motivation may also lead to poor social and occupational functioning. The range of emotional expression, capacity to think and act may be reduced, together with an inability to experience pleasure (Jones, Hacker, Cormac, Meaden, & Irving, 2012). It is customary to view the symptoms of schizophrenia as falling into three broad categories: (1) 'positive' symptoms, which are unusual by their presence (for example, hearing voices); (2) 'negative' symptoms, which are unusual by their absence (for example, restricted range and intensity of emotional expression); and (3) disorganized symptoms, which are erratic behaviors that affect speech, motor behaviors and emotional reactions. A diagnosis of schizophrenia requires continuous signs of disturbance for at least 6 months, including at least one month in which two or more symptoms are active, and at least one symptom is delusions, hallucinations or disorganized speech.

Some psychotic behaviors do not fit under the title of schizophrenia. Table 7 presents other psychotic disorders as they are described in the DSM-5.

Personality Disorders

The personality disorders (PD) describe a persistent pattern of emotions, cognitions, and behaviors that results in enduring emotional distress for the person affected and/or for others. These symptoms deviate markedly from the expectations of the individual's culture, and are pervasive and inflexible, thus frequently cause difficulties with work and social relationships, and lead to distress or impairment. The onset of PDs is usually in adolescence or early adulthood, and since the symptoms follow a chronic course, they pervade every aspect of the person's life (APA, 2013; Widiger, 2012). Certain personality disorders (e.g., antisocial personality disorder) are diagnosed more frequently in males; others (e.g., borderline, histrionic, and dependent personality disorders) are diagnosed more frequently in females. The worldwide prevalence of PDs is estimated around 6% of adults (Quirk et al., 2016).

When diagnosing PDs, the clinician must understand an individual's symptoms in their sociocultural context, considering the dynamic interaction between personality traits, developmental histories of adversity, and the current social context (Ryder, Sunohara, & Kirmayer, 2015). Additionally, the diagnostic criteria specify that the impairments in personality functioning cannot better be explained by another mental disorder, the physiological effects of a substance, or another medical condition (Möller et al., 2015).

Both the DSM-5 and ICD-10 use a categorical approach to diagnosing PDs (i.e. PDs are qualitatively distinct clinical syndromes that are different from psychologically healthy behaviors). However, Section III of the DSM-5 includes a dimensional diagnostic approach, in which individuals are rated on a series of personality dimensions (e.g. personality functioning, traits, etc.) (APA, 2013; Möller et al., 2015). Table 8 summaries the main personality disorders.

Neurodevelopmental Disorders

This category includes disorders presumed to have a neurological etiology, commonly onset early in life, and persist throughout the lifespan. The range of developmental deficits varies from very specific limitations of learning or control of executive functions, to global impairments of social skills or intelligence. Clinical descriptions of the main disorders in this category are presented in Table 9.

Neurocognitive/Organic Disorders

As opposed to the neurodevelopmental disorders that are believed to be present from birth, the neurocognitive disorders typically develop much later in life. The DSM-5 gathers these disorders under the new title of neurocognitive disorders. In the past these disorders were under the category of "organic mental disorders" (this name is still being used in the ICD-10), or "cognitive disorders," but these titles were confusing in their descriptive overlap with other disorders categories.

The main disorders under this category are Delirium and Dementia; the ICD-10 also includes organic mental disorders due to brain injury or other physical problems. *Delirium* is characterized by impaired consciousness (e.g. attention and awareness) and cognitions (e.g. memory and language) during the course of several hours or days. In most cases, delirium appears after improper use of medications, especially among elderly population who tend to use prescription medications more than any other group. *Dementia,* or major neurocognitive disorder (according to DSM-5) is a gradual deterioration of brain functioning that affects memory, judgment, language and other advanced cognitive processes. The DSM-5 distinguishes between major neurocognitive disorders, and mild neurocognitive disorders, the latter being a new classification in the DSM-5. The distinction between the two is primarily one of severity and may correspond in most progressive disorders

Table 7 Description of psychotic disorders

Disorder	Description
Delusional	Persistent beliefs that are contrary to reality, in the absence of other characteristics of schizophrenia
Schizophreniform	Similar symptoms as schizophrenia, but with a different time course: The total duration of the illness, including prodromal, active, and residual phases, is at least 1 month but less than 6 months
Schizoaffective	Presence of a mood episode (major depressive or mania) in addition to delusions or hallucinations for at least 2 weeks
Catatonia	Marked psychomotor disturbance, including at least three of the 12 diagnostic features of catatonia (e.g., stupor, catalepsy, mutism, negativism)
Brief psychotic	Presence of delusions, hallucinations, disorganized speech or catatonic behavior for at least 1 day, but less than a month
Substance/medication-induced psychotic	Prominent delusions and/or hallucinations that are judged to be due to the physiological effects of a substance/ medication
Psychotic disorder due to another medical condition	Psychotic symptoms are judged to be a direct physiological consequence of another medical condition

with earlier and later stages of the disease (Möller et al., 2015). Mild neurocognitive disorder is focused on the early stages of cognitive decline, in which the cognitive deficits do not interfere with capacity for independence in everyday activities. The different diagnoses refer to the cause of the neurocognitive disorder, such as medical conditions (e.g. Alzheimer's disease, HIV infection), abuse of drugs or alcohol, or trauma to the brain.

Summary and Conclusion

This chapter has focused on descriptions of psychological disorders as they are classified in the DSM-5 and ICD-10, the two primary diagnostic reference manuals used by clinicians today. Since their inception, each new edition of these manuals has been motivated by new research findings that have implications for the classification of psychological disorders. Accordingly, the history of these revisions reflects the changing landscape of how psychologists have conceptualized the key causes and characteristics of mental illness, as well as shifting political influences on funding for psychological research (Mayes & Horwitz, 2005). For example, the first edition of the DSM was published in 1952, a period in which Freudian psychoanalytic theories still dominated the field. Consequently, this first edition described most disorders as having a predominately psychodynamic etiology, stemming from dysfunctional or traumatic experiences in infancy or early childhood (Grob, 1991).

Since then, psychological research has demonstrated that both biological and cognitive mechanisms also contribute to the etiology and maintenance of psychological

Table 8 Description of personality disorders

Personality disorder	Description
Paranoid	Distrust and suspiciousness of others, including distorted interpretations of others' actions as malevolent and directed towards the individual
Schizoid	Detachment from social relationships, restricted range of emotional expression, and a preference for solitary activities
Antisocial/dissocial	Disregard for and violation of the rights of others, incapacity for social empathy, and irresponsible or violent attitudes towards societal norms, rules and obligations
Borderline	Instability of interpersonal relationships, self-image, affect, and control over impulses
Histrionic	Excessive emotional expression, attention seeking, and shallow affect
Avoidant/anxious	Social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation
Dependent	An excessive need to be taken care of, leading to submissive and clinging behavior and fears of separation
Obsessive-compulsive/ Anankastic	Preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, empathic personal relations, and productivity
Organic	Disinhibited social behaviors, extreme emotional lability (apathy, euphoria or irritability), and cognitive disturbances such as paranoia, reduced perseverance of actions, and impaired language production; these symptoms stem from an objective cerebral disease, damage or dysfunction
Impulsive type	Impulsive behaviors without consideration of the consequences, some related to unstable mood and outbursts of anger and violence
Schizotypal	Social and interpersonal deficits marked by acute discomfort and reduced capacity for close relationships, as well as cognitive or perceptual distortions and eccentricities of behavior
Narcissistic personality disorder	Grandiosity (in fantasy or behavior), need for admiration, and lack of empathy

disorders (Stein et al., 2010). In particular, genetics research and translational neurobiology have revealed strong links between heritable biomarkers and the expression of certain psychological disorders (Kendler, 2012). As mentioned at the beginning of this chapter, the development of the DSM-5 involved heated debate over the dimensional vs. categorical nature of psychopathology, and premise of the existence of disease entities. Many members of the psychiatric community have been dissatisfied with the sole reliance on verbal report and clinical impressions to assign patients to relatively arbitrary diagnostic categories. This has led to much public debate around the publication of the DSM-5 that is likely to continue.

This debate and the new wave of translational research it sparked remains strong, and the stated goal of many influential psychological scientists is that future diagnostic criteria will increasingly include biomarkers of disorders (e.g. specific genes

Table 9 Description of neurodevelopmental disorders

Disorder	Clinical description
Intellectual disability	The individual fails to meet expected developmental milestones in several areas of intellectual functioning, such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience
Communication disorders (language disorder, speech sound disorder, social (pragmatic) communication disorder, and childhood-onset fluency disorder)	These disorders are characterized by deficits in the development and use of language, speech, and social communication; and by disturbances of the normal fluency and motor production of speech
Autism spectrum disorder	Persistent deficits in social communication and social interaction across multiple contexts, including deficits in social reciprocity, nonverbal communicative behaviors used for social interaction, and skills in developing, maintaining, and understanding relationships. In addition, restricted, repetitive patterns of behavior, interests, or activities have to be present
Attention-deficit/hyperactivity disorder (ADHD)	Impairing levels of inattention, disorganization, and/or hyperactivity-impulsivity across multiple contexts
Neurodevelopmental motor disorders (developmental coordination disorder, stereotypic movement disorder, and tic disorder)	Disorders of the nervous system that cause abnormal and involuntary movements
Specific learning disorder	Specific deficits in an individual's ability to perceive or process information efficiently and accurately. Characterized by persistent and impairing difficulties with learning foundational academic skills in reading, writing, and/or math

or patterns of neurochemistry) as they are unveiled by progressing research (Kapur, Phillips, & Insel, 2012). Though these goals are lofty and will take decades of dedicated research to achieve, progress has been made in identifying key biological characteristics of certain disorders. The Psychiatric Genetics Consortium has made great strides in identifying genetic markers of a number of disorders, including a recently published study identifying 108 independent genetic loci associated with schizophrenia (Ripke et al., 2014). However, it should be noted that the genetic variance to virtually any form of psychopathology is too small to make a meaningful contribution to nosology. Moreover, the premise of the latent disease entities (as implied by biological abnormalities and genetic markers) has to be critically examined. The complex network perspective offers a fresh new look at this issue.

Although the recent emphasis on identifying biomarkers has dominated many programs of psychological research, the goal of improving the classification of psychological disorders is not limited to biological or translational work. For example, some researchers have approached the issue of improving diagnostic validity by emphasizing a cross-informant approach. While child and adolescent psychology have more commonly utilized a multi-informant approach to the assessment of psychological symptoms (e.g. child, parent, and teacher reports), adult psychology

relies exclusively on client self-report. A meta-analysis examining 51,000 articles published over 10 years found that only 108 (0.2%) of these articles utilized a cross-informant approach to diagnosis; among these, the mean cross-informant correlation ranged between .304 and .681, indicating wide variability between diagnoses obtained using self- and informant-reports (Achenbach, Krukowski, Dumenci, & Ivanova, 2005). The authors argue that the classification of psychological disorders can be greatly improved simply by obtaining multiple symptom reports, a process that is arguably much easier and more cost-effective than a battery of biological tests. At the same time, most experts would agree that psychiatric nosology has to move beyond symptom report in order to make significant advances.

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Psychotherapy Approaches

Barbara Depreeuw, Sharon Eldar, Kristina Conroy, and Stefan G. Hofmann

Introduction

Psychotherapy (individual, group and couple/family) is a practice designed to support individuals' mental health through several different methods. It is usually intended to provide symptom relief, reduce future symptomatic episodes, enhance quality of life, promote adaptive functioning in work/school and relationships, increase the likelihood of making healthy life choices, and offer other benefits established by the collaboration between client/patient and psychotherapist (e.g. Barlow, 2008; Carr, 2009; Hofmann & Weinberger, 2007; Wampold, 2010).

One commonly discussed factor in psychotherapy is the therapeutic alliance between therapist and client/patient, which involves both a bond between them as well as an agreement about the goals and tasks of the treatment (Karver, Handelsman, Fields, & Bickman, 2006; Lambert, 2004; Norcross, 2011). Many types of psychotherapy are available, differing in their procedures and assumptions. Some treatments are based on evidence from research and studies (Evidence Based Practice), while others are difficult to examine in an empirical way and are based more on theoretical models of human nature. Treatments may also vary in response to the "client", who is not always one individual, but can be a couple, a family or a group of people sharing the same difficulties.

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The aim of this chapter is to describe the history and the development of psychotherapy, and to provide an overview of some of the best-known schools of thought in psychotherapy. The most effective contemporary approach is Cognitive Behavior Therapy, which will be thoroughly discussed later in this chapter. Other therapy schools described in this chapter are psychoanalytic and psychodynamic therapy, person-centered therapy also known as client-centered therapy, and systemic psychotherapy.

History of Psychotherapy

For many years, humans have tried to explain and control problematic behaviors. These efforts have always been driven from the theories and models of behavior that were popular at the time (Barlow, Durand, & Hofmann, 2016). The origins of planned therapy for mental disorders likely lie within Greek culture. Hippocrates was among the first to view mental illness as a medical condition and approach it without superstition (Maher & Maher, 1985). While their initial understanding of the nature of mental illness was not always correct (e.g., believing that hysteria affected only women, due to a wandering uterus), and their treatments rather unusual (e.g., bathing for depression, blood-letting for psychosis), they recognized the treatment value of encouraging and consoling words.

With the fall of the Roman Empire, the established Greek spiritual and psychological methods virtually disappeared. The Middle Ages in Europe brought on the belief of the supernatural as a cause for mental illness. Mental illness was blamed on the Devil, demonic possession, magic, and witchcraft. Treatments were then based on the exorcism of the evil spirit or included torture to gain confessions of demonic possession (Kemp, 1990). It was obvious that the mentally ill were considered threatening and needed to be removed from society. Alongside those interventions, some mental illnesses, such as depression or anxiety, were recognized as illnesses and were treated with rest, sleep, baths and potions (Kemp, 1990). During the same time period, the first hospitals with a humanitarian motivation to treat patients with mental illness were developed. However, in the eighteenth century these hospitals were used to isolate the mentally ill people.

During the first half of the nineteenth century, a strong psychological approach to mental disorders, entitled Moral Therapy, became influential. France was first to lead this approach by establishing a reform within mental institutes to end the isolation of patients. Their reform included removing restraints and treating patients as normal persons by providing them opportunities for appropriate social and interpersonal contact (Bockoven, 1963). This Moral therapy was primarily a social intervention in which individuals were treated on large farm-like hospitals where they were required to participate in the work on the farm. The basic tenet of moral therapy was that if individuals who are profoundly ill are treated with respect and dignity and are required to participate in normal social activities, rather than be imprisoned and punished, they will once again acquire the social attributes of normal

members of society (Hersen & Sledge, 2002). This approach to patients suffering from mental illness spread to England and the U.S and eventually led to large, state-supported public asylums. However, the dissemination and use of moral therapy did not last long as hospitals became too crowded to carry out this treatment.

In the second half of the nineteenth century, new approaches to the treatment of psychopathology started to emerge from both the biological and psychological perspectives. Psychoanalysis can be traced back to 1880, when the Austrian physician, Joseph Breuer, who treated "Anna O." She coined the term "the talking cure" to describe her psychotherapy. One of his protégés, Sigmund Freud, decided to continue this line of work by describing psychoanalysis as both the science of the unconscious mind and the medical treatment of mental disease. By the 1930s, a majority of American psychiatrists embraced Freud's psychoanalysis (Mitchell & Black, 2016).

The twentieth century brought on enormous progress in the field of treatment, medically and in psychotherapy. In the 1930s the physical interventions of electrical shock and brain surgery were often used. Insulin was found to help with psychoses, and for a short term, Insulin shock therapy was used (Sakel, 1958). During the 1950s, scientists developed the first effective drugs for severe psychotic disorders, and shortly after that, benzodiazepines were discovered. This development in medicine coupled with the increasing awareness of individuals' rights in the 1960s promoted the deinstitutionalization movement. The movement started with the noble aim of treating and rehabilitating mentally ill patients within the community itself to reduce human rights violations and mitigate their suffering. As a result, more people were moved from the asylums back into community, and thus, community mental health centers were established (Barlow et al., 2016).

In the field of psychotherapy, different theories, models and approaches were explored. Freud's original psychoanalysis theory was greatly modified and expanded upon in a number of different directions (e.g. Anna Freud, 1937; Kohut, 1971). Many of Freud's students rejected his ideas and went on to new directions (e.g. Adler, 1916; Jung, 1931). A variety of new approaches were also introduced in and after the 1950s, including behavioral (Skinner, 1953; Wolpe, 1958) and cognitive (Beck, 1964; Ellis, 1958), humanistic (Rogers, 1959), Existential (May, 1961) and gestalt therapy (Perls, 1969). Instead of only focusing on psychotherapy for the individual, psychotherapists started to experiment with new settings for treatment; e.g. group and family therapy. With the advancement of science, psychotherapy evolved into a research based practice, influenced by theories and tools from biological, cognitive, social, neuro, and various other perspectives.

An overview on the history of psychotherapy reveals the progress that has been made in how we think about people with mental disorders. Today we do not consider the mentally ill as immoral or possessed by demons; instead we attribute their disturbance to a complex interaction of heredity, environmental history, personality style, and habitual ways of thinking and behaving. In the same vain, treatments have evolved from inhumane methods to empirically validated practices, and research continues to emphasize the development of new treatments that are safe and effective (Thomason, 2005).

In the following sections we will describe the main and most common approaches to psychotherapy. For each approach we will describe the theoretical foundation, treatment goal and techniques, the therapist role, and its support and critiques. We will start with a broad overview of cognitive behavioral therapy and then will more concisely describe psychoanalysis and psychodynamic therapy, person-centered therapy and systemic therapy.

Traditional Cognitive Behavioral Therapy

Cognitive Behavioral Therapy (CBT) combines elements of behavioral therapy and cognitive therapy whose theoretical and procedural approaches are highly compatible. The central notion of CBT is that behaviors and emotional responses to external events and situations are not directly caused by these events or situations per se, but by the perceptions and interpretations of these events and situations (Hofmann, 2014).

Theoretical Foundation

A detailed description of the development of CBT and its theoretical models follows.

Learning principles. One important influence of CBT comes from learning theory and behavioral models. At its most extreme version of behaviorism, the nurture position is the idea that nothing is predisposed and individual behavior is shaped as a result of experiences. Even though this extreme point of view was abandoned (Öhman & Mineka, 2001), CBT stresses the importance learning experiences and the here and now. This implies that behaviors in psychopathology are developed through the same laws of learning that influence the development of all behavior.

In the 1920s Pavlov started to research conditioning and associative learning in dogs. In short, he posited that classical conditioning happens when a neutral stimulus (e.g. a tone) acquires meaning after repeatedly being paired with a stimulus that elicits a spontaneous biological reaction (Unconditioned stimulus—UCS/Unconditioned Reaction—UCR, e.g. food and salivation reaction). If the association is well established, the neutral stimulus becomes conditioned (Conditioned Stimulus—CS) and will elicit the same biological reaction (Conditioned Reaction—CR, e.g. salivation reflex) without the appearance of the actual cue that originally elicited the biological reaction (the food). Building on this basic learning idea in dogs, Pavlov was the first to link general associative learning to psychopathology. By requiring dogs to make difficult sensory discriminations, when the result was them not receiving food that they were expecting, Pavlov's dogs engaged in new (aggressive) behaviors, like barking, agitation, biting the equipment; Pavlov described this as 'experimental neuroses' (Pavlov, 1928). Around the same time Watson and Rayner (1920) introduced the term 'conditioned

emotional reaction'. They described a case of an 11-month old infant, Albert B. (Little Albert), who arguably became the most well-known baby in psychological science. In the first phase of the experiment, Watson and Rayner presented a rat to the infant, and he didn't show any fear reaction. The rat was considered a neutral stimulus. In a second phase of the experiment, touching the rat was paired with a loud noise, an aversive reinforcer. After a few pairings, Little Albert, who at first did not show any anxiety reaction when white animals with fur were presented to him, became upset and anxious when he was exposed to any stimulus that resembled the rat, like a rabbit, a white beard, a dog, a fur coat, a Santa Claus mask, etc. Watson and Rayner concluded that fear can be learned and that conditioning plays an important role in developing fear reactions. They also learned that conditioned reactions can disappear if they are not continually reinforced by the consequence, which resulted in a process called extinction. This idea was adopted and implemented by Mary Cover Jones to treat children with phobia's. Until now, almost 100 years later, these conditioning procedures are used to study new forms of CBT treatments (Craske, Hermans, & Vansteenwegen, 2006; Hofmann, 2008).

Apart from classical conditioning, defined as a procedure that involves reflexive responses, Watson's ideas (1913) that the science of human behavior had to be based on observable events and the relationships among those events, influenced the work of Skinner and colleagues. Based on Thorndike's Law of Effect, Skinner described the process of operant conditioning (Hermans, Eelen, & Orlemans, 2007; Skinner, 1948). This type of learning happens when an organism's initially random behavior increases or decreases based on a reward or punishment that follows the behavior. Thus, behavior changes as a function of the consequence of the behavior and becomes controlled by its reinforcement. The first experiments were done with animals; for example, a rat can learn that a light predicts food if it pushes a lever or a dog can learn that it can escape a shock by jumping to the other side of the cage. Skinner even made pigeons play Ping-Pong by reinforcing successive approximations to a final set of behaviors. Every time the pigeon moved towards the Ping-Pong ball, he was reinforced by a food pellet, which resulted in the ability to play Ping-Pong; this process is known as *shaping*. Another type of conditioning that is relevant for the current understanding of behavior and psychopathology is *vicarious conditioning* (Bandura, Ross, & Ross, 1963). The main idea in various conditioning is that all behavior (adaptive and non-adaptive) can be learned by observation.

Although conditioning is incomplete in the conceptualization of psychopathology, classical and operant conditioning is still very relevant in behavioral assessment and for understanding the maintenance of psychopathology. The fundamental research of stimulus (over)generalization, modeling, and other forms of learning, still influences the current clinical case conceptualization and popular therapy techniques. In summary, learning psychology substantially contributed (and still is contributing) to the current and widely used treatments of (cognitive) behavior therapy (Craske et al., 2006; Hofmann, 2008).

Disappointed in the outcomes of psychoanalysis and inspired by learning psychological principles, Wolpe (1961) created systematic desensitization, a new technique to treat people with anxiety. This technique was not that different from Watson and Jones'

approach to the children that suffered from phobia's in the 1920s, but times had changed, and the 1960s allowed more room for new therapy approaches besides psychoanalysis. With the founding father, Wolpe, as their supervisor, Rachman and Eysenck disseminated the new therapy approach in the United States and United Kingdom, respectively (Eelen & Vervliet, 2006; Eysenck & Rachman, 1965; Rachman, 1967).

Behavior therapy is often misperceived as a set of techniques that therapists apply to reduce symptoms without any knowledge of the problems that a client is presenting. This interpretation is vastly incorrect; behavior therapy is influenced by the empirical tradition and uses the empirical cycle to approach a client's problem: collecting information, making (behavioral) assessments, creating hypotheses, applying therapy techniques, and evaluating the results of treatment followed by a feedback loop in case the results are not as expected (Hermans et al., 2007). So, before applying behavior therapeutic techniques, a behavior therapist starts with a thorough behavioral assessment in order to make a case conceptualization and a functional analysis. The analysis entails the following questions: what is the problematic behavior, what maintains the problematic behavior, what is the frequency of the behavior, and in what contexts does the behavior appear or disappear. Attention is focused on the learning history using (semi)structured interviews and objective behavioral measures. Clients are asked to monitor their problematic behaviors, their antecedents and consequences. Nowadays there is more of an integration of cognitions in functional analysis, but behavior therapists initially only made the distinction between the stimulus (what triggers the behavior), the organism (reactions that are triggered in the organism, like emotions, cognitions or physiological sensations), the response (the overt behavior) and the consequence of the behavior (different types of reinforcement). The functional analysis investigates how the function of a behavior serves the person. For example, if someone takes the stairs instead of going into an elevator, it is possible that this person is apprehensive to be stuck in an enclosed place, but it is also possible that this person wants to be healthy and exercise more. In the first case, it would be appropriate to teach the person to respond differently to the anxiety for enclosed places; in the latter case, it is likely healthy behavior that a therapist wants to encourage. Therefore, it is important to identify the different functions of a particular behavior as it defines the techniques that will be applied in further treatment. In behavior therapy, evaluation of the therapy outcome is important. The thorough assessments prior to the start of therapy are typically used to create a baseline measurement to evaluate the results of therapy at a later stage or at the end of therapy; this data can show if a client made progress or not.

Cognitive influence. In the 1950s–1960s behavior therapy achieved the status of a major treatment beside the preceding psychoanalysis and Rogers' humanistic person-centered therapy (Eelen & Vervliet, 2006). In the meantime, cognitive psychology, with its computer analogies and information processing language, was beginning to influence the field of clinical psychology. From their perspective, behaviorism was too strict. The role of thought processes and mental constructs became appealing for the scientific world, and was soon welcomed as a tool for behavior therapists to work with appraisals, beliefs and attributions that clients presented in therapy. Cognitions were perceived as mediators between contexts and behaviors. Independently from

each other, Ellis (1973) with his Rational Emotive Therapy and Beck (1976) with his cognitive therapy for depression, made the distinction between an Activation event (A), that activates the individual Belief System (B) and results in an (emotional) consequence (C). The basic notion of cognitive therapy is that the cognitive interpretation of a certain event influences emotions and behaviors in reaction to that event, but does not influence the situation itself (Beck, 1995; Hofmann 2016a, 2016b; Hofmann, Asmundson, & Beck, 2013). Cognitive therapists assume that personal schemas (based on their learning history) are underlying constructs that influence how people perceive themselves and the world. Based on these schemata or core beliefs, people have all kinds of automatic (irrational) thoughts in specific situations, which often confirm their underlying schema (Beck, 1995). For example: if a group of peers continues to talk with each other when a person with social anxiety enters a room, it is likely that this person interprets this behavior of the group (not talking to him) as a confirmation that those people are not interested in him. He would likely draw the conclusion that this is as a sign that he is boring, and therefore, that people are not interested in conversing him. Cognitive therapists use techniques like Socratic dialogue and behavioral exercises to identify thought distortions and to change thought processes because they assume that changing the irrationality of these thoughts will change the emotional responses as a result. Certain sets of self-defeating thoughts were identified for particular disorders; this has been called the cognitive specificity hypothesis and helps in conceptualizing specific disorders and their treatments (Beck, 1976; Hofmann et al., 2013). Later in this chapter we will expand on the therapy technique of cognitive restructuring.

More recently an interesting contribution was made from the theoretical models of cognitive psychology. Unconscious cognitive processes like attentional bias, priming and subliminal perception can be used to measure implicit attitudes (De Houwer, Teige-Mocigemba, Spruyt, & Moors, 2009). The advantage of these measures is that researchers do not have to rely on introspection; people are not asked what they think or feel, rather people's cognitive processes can be measured via behavioral responses on particular tasks. A common example is the emotional Stroop task (Gotlib & McCann, 1984), which is simply an adaptation of the original Stroop task (1935). In the emotional version, the words that are presented are not colors, but are emotionally relevant words. The idea behind this task is that people process emotional relevant words slower, and therefore, show a longer reaction time. This fundamental research has become very popular and shows continued promise as it provides knowledge about cognitive mechanisms that may underlie behaviors and, therefore, may influence future psychotherapies.

Over the years the distinction between behavior therapy and cognitive therapy has faded. CBT is the most extensively researched form of psychotherapy (Hofmann, 2014; Hofmann, Asnaani, Vonk, Sawyer, & Fang, 2012). This empirically supported therapy approach is systematic and goal-oriented. The focus of the intervention lies on current problems and what maintains the symptoms, rather than on the original cause and onset. The majority of the CBTs are described in manuals designed around specific DSM diagnoses (for examples, see Safren, Sprich, Perlman, & Otto,

2005; Barlow & Craske, 2006; Hofmann & Otto, 2008; Gilson, Freeman, Yates, & Morgillo Freeman, 2009; Hope, Heimberg, & Turk, 2010). These manuals provide detailed descriptions about specific disorders, often including an empirical model for case conceptualization and accompanying assessment tools. There is also a detailed description of prescribed interventions and how they have to be conducted in an effective treatment. The treatments are short-term by definition and include a limited number of sessions.

CBT is a problem-oriented approach that aims to alleviate symptoms of psychopathology leading to an improvement in behavioral functioning or a total remission of a psychiatric disorder (Hofmann et al., 2012). The focus lies on problematic behaviors, maladaptive cognitions, and accompanying emotions. More so, goalsetting is an important part of the therapy process (Beck, 1995). In the beginning of therapy, the client and the therapist discuss the client's goals and expectations, delineating concrete observable outcomes that indicate the attainment of each goal. Based on these goals and expectations, a therapy plan is developed and presented to the client.

In CBT, the therapist and the client collaborate together in a transparent way (Hermans et al., 2007). The therapist is viewed as an expert in the therapy techniques and the psychopathology or maladaptive behavior and the client is viewed as an expert in their own life and problem presentation. The salience of this collaborative relation is highlighted in the ongoing monitoring of thoughts, behaviors etc., that clients are asked to do (through homework assignments and exercises in session) and the active role that clients take on during therapy sessions. The CBT therapist plays an educational role as a skill trainer, who can be directive and confronting, but also supportive and empathetic (Kramer, Bernstein, & Phares, 2009). The therapeutic relation is used to create an environment where a client can learn to respond differently to an emotional state in order to decrease problematic symptomatology. Additionally, in newer applications of CBT, like online therapy programs or psycho-educational courses, there is minimal use of the therapeutic relationship.

Techniques

The following sections aim to describe the therapy techniques that were developed in both behavioral and cognitive therapies because they are often combined and incorporated in CBT together. This is not an all-inclusive list, but an overview of the most commonly used therapy techniques in CBT today.

Psycho-education. Cognitive-behavioral therapy usually begins with psycho-education. The main goal of this session is to inform the client about the diagnosis and its cognitive behavioral conceptualization. By providing this information, the therapist aims to increase the client's understanding of the presenting problems in order to increase acceptation (White, 2000). Ideally psycho-education happens in an interactive dialogue with the client; it encourages the client and therapist to reach a mutual understanding of the presenting problems and devise a treatment plan accordingly. This process also typically increases the client's therapy adherence.

Three component model. One of the main CBT tools used to break down a patient's emotional experience is the three-component model, which consists of cognitions, behaviors, and physical sensations/feelings (Barlow et al., 2011). The cognitive component represents the thoughts an individual has in response to a particular emotion, e.g. anxiety. In psychopathology, these thoughts are often automatic, distorted and negative. The behavioral component is a description of what a person does (or has the urge to do) when responding to an emotional state. These behaviors are also defined as emotion driven behaviors. The physical component describes the way the body reacts in response to the emotional state. For example, an emotional experience of a person suffering from panic disorder can present as follows: experiencing physical feelings like heart pounding, sweating, and shortness of breath that are accompanied by the thoughts, "If this gets worse I will die of a heart attack, I can't handle this!" A behavioral response to said panic symptoms could then be: refraining from drinking coffee or physical exercise. The three-component model is interactive with each component impacting the other two. There is often a negative influence of one component on another and individuals can get stuck in a vicious cycle of negativity and/or self-destruction. For example, in the panic disorder case, avoidance of exercising (behavior) associates exercising with the thought (cognitive): "Exercising is dangerous; a raise of my heart beat is dangerous", which will increase the anxiety and the accompanying physical sensations, like heart pounding and shortness of breath. In this case, the person with panic disorder can be stuck in high anxiety and high avoidance behavior that maintains and often intensifies the panic disorder (Barlow & Craske, 2006). There are variations of this model; for example, some CBT therapists use the distinction proposed by cognitive psychologists and break the client's experiences up into situations, thoughts, emotions and behaviors (Beck, 2005; Hofmann, 2011; Hofmann et al., 2013).

Cognitive restructuring. To understand why cognitive restructuring is a helpful therapy technique, clients must understand the basic assumption that the situation in which we find ourselves does not determine our emotional state, but rather that our thoughts are responsible for our perceived emotional state (Beck, 2005). Thoughts are very influential on the client's mood, behavior and physical feelings. Thoughts happen automatically and, in people with psychopathology, are often distorted, negative, and internalized (Beck, 1967; Hofmann, 2011, 2014). This results in a cascade of maladaptive behavior and negative emotions that reinforces the negative thought process. Cognitive restructuring involves treating thoughts as hypotheses, rather than truths. It aims to challenge clients' thoughts in order to change the emotional state and motivate engagement in behavioral experiments. To identify maladaptive cognitions, therapists encourage clients to use monitoring forms where they can recognize and record their distorted thoughts, behaviors, and emotions during particular situations (Buhrman, Fältenhag, Ström, & Andersson, 2004; Mattila et al., 2010). Based on the data from these monitoring forms, the client's maladaptive thought patterns can be identified and addressed in therapy.

Restructuring is ideally done in a Socratic dialogue so that clients discover for themselves that their thinking is irrational or distorted, and that in-turn, their thinking affects how they behave in certain situations. After identifying concrete negative

thoughts in an objective situation, the therapist challenges the distorted beliefs by questioning the thoughts: e.g. 'Is this thought true?', 'What is actually the worst that can happen?', 'If the worst consequence were to happen, would you be able to cope with it?', 'Do you have evidence for that?'… Being asked these questions, in a non-judgmental and gentle manner, helps the client adopt a more rational view of the situation and identify conflicting and supporting evidence of their particular assumptions. Through hypothesis testing, cognitive restructuring aims to modify the client's behavior and lets them experience a more realistic perspective about the targeted situation. There are other cognitive techniques with the same objective: listing pros versus cons, creating downward arrows, pie charts and so forth (Dattilio, 2000; O'Donohue & Fisher, 2009). Using these cognitive restructuring techniques in concrete situations helps the clients generalize their conclusions to a broader perspective about the world. Different ways that thoughts can be distorted are outlined in a list of thinking traps such as: catastrophizing, probability overestimation, jumping to conclusions, and mindreading. For a more in-depth list of thinking traps, refer to the work of Greenberger and Padesky (1995). The aim of identifying these patterns of distorted thinking is to automatize a more adaptive way of thinking.

Behavioral experiments and exposure with response prevention. Following cognitive restructuring (or independent from it), it is useful for clients to test their hypothesis by engaging in behavioral experiments, i.e. new behavior. Behavioral experiments provide the opportunity to examine the validity of their assumptions and engage in adaptive coping strategies. For example, a person that never expresses his opinion because he is concerned that people will not listen to him is encouraged to share his opinion and observe what happens. Designing behavioral experiments is an idiosyncratic process and needs to be taken with careful consideration (Barlow, 2008; Hofmann & Reinecke, 2010; Vorstenbosch, Newman, & Anthony, 2014).

Behavioral experiments often mean exposing oneself to a feared or highly uncomfortable situation. It is mostly used in the context of anxiety disorders, but in the modern CBT, it has been applied in broader contexts, e.g. experiencing emotions for people with experiential avoidance behavior (Craske & Barlow, 2008), as behavioral activation in depression (Dimidjian, Barrera, Martell, Muñoz, & Lewinsohn, 2011; Lejuez, Hopko, & Hopko, 2001), as cue exposure in addictive behavior (Drummond, Tiffany, Glautier, & Remington, 1995), or even as exposure to cues of a deceased loved one in therapies for complicated grief (Bryant et al., 2014). In short, exposure as a therapy technique for anxiety disorders means confronting clients with a feared stimulus (e.g. situation, image, activity, sensations, etc.) in order to learn that their feared outcome does not happen (no harm) (Craske, Treanor, Conway, Zbozinek, & Vervliet, 2014) and that their fear declines as they stay in the situation without attempting to decrease the threat (Foa & Kozak, 1986). Exposure can be conducted in vivo (in the feared situation itself) or imaginal (in client's imagination). For example, a useful in vivo exposure exercise for a client with social anxiety disorder, who is very apprehensive about being judged by others, could be giving a public speech for a large audience. Another example of exposure could be doing a hyperventilation provocation for a client with panic disorder who is afraid of internal sensations like dizziness or shortness of breath. For people with PTSD, a combination of imaginal

exposure (reliving the trauma memory) and in vivo exposure (e.g. revisiting the place where the trauma took place) is indicated (Foa & Rothbaum, 1998). An adequate amount of time in the feared situation is vital so that the client can reach the conclusion that what they expect to happen, in fact does not happen. Starting exposure with the client's most feared situation, or alternatively, gradually building upon a hierarchy of feared situations does not impact the outcome of the exposures as long as the exercises are conducted systematically and repeatedly (Craske et al., 2014). Moreover, in some situations, it is less useful to conduct exposures gradually; for example, for people with the fear of flying, one either gets on the plane or does not. Once one is aboard the plane, it is very difficult to get off. This type of exposure is called *flooding* and can be equally as effective as gradual exposure.

Avoidance behavior is the central target of exposure exercises. Therefore, it is important to include response prevention in conducting exposure exercises. If people engage in exposure to a threat, they should not be able to escape the threat or engage in safety behaviors. The underlying assumption is that escaping or avoiding the threat maintains the anxiety (or maladaptive behavior patterns) (Hofmann & Otto, 2008). Therefore, clients must refrain from all behavior aimed at decreasing the feeling of anxiety or escaping the perceived threat. For example, the person with social anxiety disorder who gives a public speech as an exposure exercise must focus on looking at the audience if looking away makes them feel safer. Similarly, for the person that suffers from panic disorder, it is important to do the hyperventilation provocation without carrying anxiety reducing medication or water. Exposure exercises are designed to give clients the opportunity to learn that they are still able to function despite their anxiety, that their fear is often not as bad as they expect, and that they can tolerate the discomfort elicited by the exposure exercise (Craske et al., 2014).

Contingency management. Contingency management is a therapy technique based on operant conditioning. It is used to change maladaptive behavior into desired behavior. Through this technique, adaptive behavior is rewarded and maladaptive behavior is punished (punishments are nowadays less used as positive punishment, e.g. not slapping a child, but rather taking away privileges). Tokens are often used as symbols that can be exchanged for real reinforces. This form of behavioral analysis aims to change behavior; the challenge of the analysis is to target the correct behavior and to find the most effective reinforcement and punishment. It is commonly used and shown to be effective in treating children with behavioral problems, like ADHD (Dovis, Van der Oord, Wiers, & Prins, 2012) and addictive behaviors (Schumacher et al., 2007). Stimulus control techniques are also necessary to reinforce adaptive behavior in the appropriate context. For example, a child with ADHD has to learn to sit still in class, but can play loudly at the playground to release energy. In a contingency management program, sitting still in class will be reinforced in class, but not at the playground. Certain behavior (sitting still) becomes controlled by a certain stimulus (class context), but is not by another stimulus (playground context). Operant conditioning techniques like shaping (as described above, behavior tendencies reinforced until the goal behavior is achieved) and time-out (removing a child from a desired environment as a punishment) are useful contingency management techniques to change behavior.

Problem-solving. Problem-solving is another important skill that is addressed in CBT protocols (Beck, Rush, Shaw, & Emery, 1979; Leahy, Holland, & McGinn, 2012; Nezu, Nezu, & D'Zurilla, 2014). D'Zurilla and Nezu (2010) define problem solving as a self-directed cognitive behavioral process by which a person (or a group of people) attempts to identify or discover effective solutions for specific problems in their everyday life. Although its origins are in behavior modification, the cognitive tradition broadened the scope of its application. Cognitions are used to facilitate feelings of self-control in clients and maximize the generalization and maintenance of behavioral change. When under distress, whether due to anxiety or depression, one's attention narrows due to a more limited cognitive processing capacity. Therefore, it is very useful to help clients find possible solutions for their problems (Bilsker, Anderson, Samra, Goldner, & Streiner, 2009). Problem solving therapies exist in different forms and are applied to many areas of psychopathology, like depression (Nezu, Nezu, & Perri, 1989), anxiety (Ladouceur, Blais, Freeston, & Dugas, 1998), internalizing and externalizing problems (Kazdin, Esveldt-Dawson, French, & Unis, 1987), etc. By definition, problem solving starts by identifying the formulation of the problem, coming up with alternative solutions, and then generalizing the solutions. Coming up with alternative solutions involves a phase of brainstorming possible solutions and their respective consequences. When a list of all possible solutions has been generated, clients are then encouraged to make a decision and select their solution. The final step is implementing and verifying the solution. Clients are encouraged to observe and evaluate the outcome of their selected solution. It is noteworthy to understand that problem-solving coping is helpful for clients with solvable problems (for example if the problem can be solved by changing one's behavior or when a person has an influence on the situation). In situations with unsolvable problems that may be ambiguous or uncontrollable (e.g. death of a loved one, chronic pain, etc.), focusing more on emotion regulation and relaxation is a more effective approach (Livneh & Antonak, 1997).

Relaxation. Relaxation techniques, like Progressive Muscle Relaxation (PMR), are useful tools to reduce distress and arousal in the body (Barlow, 2008; Day, Eyer, & Thorn, 2014). PMR is the most commonly used technique in CBT manuals. It was created by Jacobson in 1934 and then later adapted by Bernstein and Brokovec to fit Cognitive Behavioral Stress Management (Bernstein & Borkovec, 1973). PMR involves tensing and relaxing various muscle groups, one at a time. Experiencing the difference between tension and relaxation alters the perception of relaxation. There is a sequence of steps (with a number of muscle groups addressed) that must be followed in a specific order to obtain full body relaxation. The end phase of PMR is a conditioned cue (i.e. 'relax'), which can direct people to relax in just a few moments without tensing the muscles in advance. Relaxation is a skill that needs to be practiced before it becomes automatic, so it can be applied to stressful situations.

Homework practice. The systematic practice of a client's acquired CBT skills and techniques in between sessions (at "home") is a vital part of effective CBT. By engaging in homework assignments, a client can practice his or her learned skills in daily life and become their own therapist. It encourages clients to generalize the

skills from a therapy context to reality; this is a crucial determinant of their long-term emotional health. Individuals who complete the assigned homework have significantly better outcomes than those who fail to do the homework (Kazantzis, Deane, & Ronan, 2000) or that only focuses on work during sessions (Beutler et al., 2004). Moreover, the more homework that is completed, the better the therapy outcomes (Burns & Spangler, 2000).

Contemporary CBT

During the last three decades, psychologists have been developing a number of therapies that differ from the traditional CBT described above. Some authors have called this collection of therapies "the third-generation CBT", or "the third wave" (Hayes, 2004; Öst, 2008). The "first wave" is considered to be behavior therapy developed in reaction to the 1920s unscientific therapy techniques. The first wave's behavior therapy is characterized by scientifically applied techniques based on learning psychology, with a focus on changing behavior and emotions. The "second wave" (1970–1980) is understood as the addition of cognitions, which shifted the focus from solely behaviors to altering thoughts in order to change problematic behavior. Finally, the third-generation CBT therapies are characterized by several common components: the focus on mindfulness (being in the present moment), acceptance or acknowledgement of inner sensations, behavior change motivated by the focus on client's values and life goals, interpersonal relationships, etc. (Öst, 2008). In summary, the third wave seems to broaden the attention to psychological, contextual and experiential areas. However, it has been argued that the so-called third wave is not that different from traditional CBT (Hofmann & Asmundson, 2008). In the following section, we describe three examples of therapies developed in this new generation of CBT.

Mindfulness-Based Therapy

Mindfulness is a mental state achieved by focusing one's awareness on the present moment, acknowledging one's feelings, thoughts, and bodily sensations, while encouraging openness, curiosity, and acceptance (Bishop et al., 2004; Kabat-Zinn, 2003; Melbourne Academic Mindfulness Interest Group, 2006). Mindfulness differs from traditional CBT in that it does not aim to change thoughts, but encourages clients to perceive thoughts as just thoughts. Therefore, it is not necessary to dig deeper into the content of these creations of the mind, nor to challenge them. Mindfulness originates from Eastern traditions and has been practiced for thousands of years. Mindfulness-Based Therapies (MBTs) integrate the essence of traditional mindfulness practices with contemporary psychological practices in order to improve psychological functioning and wellbeing (Gu, Strauss, Bond, & Cavanagh,

2015). Mindfulness-based stress reduction (MBSR; Kabat-Zinn, 1982) and mindfulness-based cognitive therapy (MBCT; Segal, Williams & Teasdale 2012; 2013) are the most scientifically evaluated and implemented MBTs.

At its core, mindfulness practice assumes that intentional awareness of moment-to-moment cognitive experiences and automatic cognitive processing cannot occur simultaneously. Thus, when practicing mindfulness and experiencing the present moment non-judgmentally and openly, it is more difficult to be affected by stressors or engage in repetitive negative thinking such as worries and ruminations. For example, if a person with depressive thoughts observes his thoughts and sensations in a non-judgemental way, he will not engage in a rumination process about what he could have done differently (and better) in life and then judge himself for any perceived shortcomings. Mindfulness practice is about the willingness to observe inner sensations, acknowledge and return, over and over again, refusing to be led by the mind into the past or the future, always coming back to the immediacy of what is actually being experienced. This mindset aims to increase consciousness and awareness in order to detach from maladaptive cognitive patterns, shift to a more functional model of thinking, improve problem solving, and reach inner peace, harmony, and quality of life. During treatment, clients learn to internalize and develop their own mindfulness practice and discover how to adapt and incorporate learned exercises in ways that best fit personal preferences and needs (Twohig, Widneck, & Crosby, 2013).

Acceptance and Commitment Therapy

Acceptance and Commitment Therapy (ACT) emerged from behavior therapy and was developed by Steven Hayes (Hayes, Luoma, Bond, Masuda, & Lillis, 2006; Hayes, Pistorello, & Levin, 2012; Hayes & Wilson, 1994). With Relational Frame Theory (RFT) as its theoretical background (Hayes, Strosahl, & Wilson, 1999), ACT highlights the ways that language (represented through thoughts) traps clients into attempts to wage war against their internal lives. Thus, the goal of ACT is to help clients consistently choose to pursue their values in the presence of difficult or disruptive "private" (cognitive or psychological) events. ACT uses acceptance and mindfulness strategies to promote behavior change compatible with personal values and to increase psychological flexibility. Hayes and colleagues define a person's psychological flexibility as their ability to make contact with inner experience in the present moment and, given the possibilities involved in that particular moment, engage in value based and goal oriented behavior. Unlike traditional CBT, ACT does not aim to identify and correct cognitive distortions or regulate physiological sensations. It uses an acceptance-based approach to deal with inner sensations: using techniques like mindfulness (being present), cognitive defusion, and self-as-context where inner sensations happen (instead of fusing with them). Metaphors are often used to present these techniques. Commitment to value based action is

important in the pursuit of a person's life goals and results often in skill-development, goal-setting, exposures etc. (Hayes et al., 1999).

Findings indicate that ACT is more effective than treatment as usual or a placebo. It has been found to be beneficial in treating substance abuse, psychosis, anxiety, depression, OCD, chronic pain, burnout at work and eating disorders (For review and meta-analysis see Hayes et al., 2006, 2012).

Dialectical Behavioral Therapy

Originally Dialectical Behavior Therapy (DBT) was developed by Linehan (Linehan, Heard, & Armstrong, 1993) for borderline personality disorders, especially for people with high suicidality. This approach is the gold standard for borderline personality disorder and has been shown to be effective for substance abuse (Dimeff & Linehan, 2008), eating disorders (Safer, Robinson, & Jo, 2010), ADHD (Hirvikoski et al., 2011; Fleming, McMahon, Moran, Peterson, & Dreesen, 2015), depression (Harley, Sprich, Safren, Jacobo, & Fava, 2008; Lynch, Morse, Mendelson, & Robins, 2003), and childhood abuse with trauma and depression (Bradley & Follingstad, 2001). DBT is a skill-based treatment that aims to help people with dysregulated emotions to become more comfortable with their daily emotional, cognitive, behavioral and interpersonal patterns. The core of the treatment is the dialectical approach (two concepts that seem to be opposite are ultimately connected and can co-exist at the same time). The overarching dialectical dimension takes into consideration acceptance in one way and change in another. Clients are encouraged to accept who they are and their current situation, but in the meantime, understand that change is necessary. Other dialectical strategies represent this overall dialect: problem solving versus validation as core strategy; irreverent versus reciprocal as communication style; consultation-to-the-patient versus environmental intervention for case management and interaction style; and integration strategies like dealing with therapy disruptive behavior, suicidal behaviors, ruptures in the therapeutic relationship, and ancillary treatments. The DBT skill training is divided into modules to increase flexibility: mindfulness and distress tolerance are the acceptance based modules; interpersonal effectiveness and emotion regulation are the change based modules.

Support and Critics

People who seek therapy often have a specific desire to reduce their symptomatology; CBT is a highly attractive method because it is goal oriented and aimed at reducing problematic symptoms. Moreover, because of its skill training approach, CBT can be adapted into different forms and applied to a variety of populations. CBT is also relatively brief and therefore cost-effective for the average consumer.

CBT is the most researched form of therapy, and has been shown to be highly effective. There is a consistent finding that CBT is equally or more effective than other forms of treatment, including medication and other therapies (Butler, Chapman, Forman, & Beck, 2006; Hofmann et al., 2012).

Alongside this great support, some critics argue that the data about the long-term effects of CBT in comparison to other therapy forms are inconsistent (DeRubeis & Crits-Christoph, 1998). In addition, others claim that since the goal of CBT is symptom relief, it ignores other important components of psychotherapy, such as enhanced insight, improved object relations, or increased self-awareness. Moreover, psychoanalytic critics state that cognitive restructuring only replaces old defenses with intellectualization and rationalization defenses, without dealing with the real conflict that underlies the symptoms (Prochaska & Norcross, 2014). These issues are effectively addressed in future developments of CBT, which focus on therapeutic processes of treatments rather than medically-defined disorders (Hayes & Hofmann, 2017).

Psychoanalysis and Psychodynamic Therapy

Psychoanalysis was made famous in the early twentieth century by one of the best-known clinicians of all time, Sigmund Freud. Psychoanalysis is a theory and a method for understanding the development and function of human psychology and emotions (Hersen & Sledge, 2002). Psychoanalysis therapy was the first systematically designed and organized talk therapy for mental disorders. This approach stresses that mental health problems come from unconscious conflicts, desires and psychological defenses against anxiety. Early childhood experiences are highlighted in determining mental health in later life. Freud initially suggested that mental health problems arose from efforts to push inappropriate sexual urges out of conscious awareness (Freud & Breuer, 1895). Later, Freud more generally suggested that psychiatric problems were the result of tension between different parts of the mind. Freud believed that bringing unconscious conflicts into conscious awareness would relieve the stress of the conflict by reducing defensive mechanisms, and help the client to develop insight into the behavior related to the symptoms (Freud, 1920).

Theoretical Foundation

Freud presented his psychoanalytic theory of personality through different models that aim to explain how the mind is structured (topographic model) and functions (structural model). He argued that human behavior is the result of the interactions among three component of the mind: the id, ego, and super ego, and that it is influenced by unconscious psychological conflicts between those components. Dynamic interactions among these fundamental parts of the mind are thought to progress through five distinct psychosexual stages of development (psychosexual model).

The topographic model. In this model Freud described the mind's structure by dividing it into three conscious levels. The consciousness is on the surface and consists of thoughts that are the focus of the attention in a current moment. Then the preconscious consists of all which can be retrieved from memory and accessed by shifting our attention. The third and most significant region is the unconscious; here lies the processes that are the cause of most behavior, including wishes and impulses that do not enter the consciousness. The unconscious cannot be experienced without the use of special therapy techniques. Freud struggled to find a method that would dismantle or dissolve the defenses rather than temporarily lull them, as he believed hypnosis did. Around the turn of the century, he settled on the method of free association, which became the backbone of psychoanalytic technique and will be explained below (Mitchell & Black, 2016).

The structural model. According to Freud, the mind has three major parts of functioning: the id, ego and superego. The id operates at an unconscious level according to the pleasure principle and is the source of the sexual and aggressive drives. These two basic drives of the id are continually working in opposite directions. Eros, or life instinct (libido), helps the individual with survival needs; it directs life-sustaining activities such as respiration, eating and sex. In contrast, Thanatos or death instinct, is viewed as a set of destructive forces present in all human beings. When Thanatos is directed outwards onto others, it is expressed as aggression and violence. Finally, the id processes information through the primary process. This process is the unconscious thinking of the id, that strives for a discharge of energy and focus on immediate gratification of instinctual demands and drives. Primary process uses symbols and metaphor, disregards logic, and manifest itself mainly during dreaming, in patients in psychotic states, and in young children (Freud, 1921).

Counterbalancing the id is the superego: the mental agency that incorporates norms from one's parents, family and culture. It develops during early childhood (when the child identifies with the same sex parent) and is responsible for ensuring moral standards of an individual. The superego operates on the morality principle and motivates us to behave in a socially responsible and acceptable manner. The superego also contains the ego ideal, or how one would ultimately like to be. The id and superego are usually in conflict: the id wants to release its urges and drives, while the superego aims to inhibit these drives to direct behavior in a socially appropriate way.

The ego assumes the role of mediating the conflict between the id and the superego. The ego develops from the id during infancy. The ego's goal is to satisfy the demands of the id in a safe and socially acceptable way. In contrast to the id, the ego follows the reality principle as it operates in both the conscious and unconscious mind.

The basic conflict of all human existence is that each element of the psychic apparatus makes demands upon us that are incompatible with the other two. Thus, inner conflict is inevitable and is the source for anxiety or neuroses, which are functional mental disorders. The ego deals with this anxiety by adopting defense mechanisms that keep anxiety away from awareness, which sometimes interferes with functioning. For example, using sublimation can help in transferring unacceptable impulses into socially acceptable expression, but using denial might distort reality (Kramer, Bernstein, & Phares, 2014; Mitchell & Black, 2016).

The psychosexual stages. Freud believed that children are born with a libido—a sexual (pleasure) urge. There are a number of stages of childhood, during which the child seeks pleasure from a different 'object'. The stages—oral, anal, phallic, latency, and genital—represent distinctive patterns of gratifying the basic needs and satisfying the drive for physical pleasure. Freud proposed that if the child experienced sexual frustration in relation to any psychosexual developmental stage, he or she would experience fixation that would create symptoms of anxiety and persist into adulthood as neurosis (Kramer et al., 2014).

Techniques

According to Freud, when clients understand the real, and often unconscious, reasons they act in maladaptive ways, they will no longer have to continue behaving in such ways. This understanding is accomplished by recognizing one's inner wishes and conflicts as well as the systematic tracing of how unconscious factors have determined past and present behaviors and affected relations with other people (Freud, 1890, 1910). Thus, the main goals of psychoanalysis therapy are: (1) Intellectual and emotional insight into the underlying causes of the client's problems; (2) Working through or fully exploring the implications of those insights; (3) Strengthening the ego's control over the id and the superego. Taken together, the ultimate goal is to reconstruct the client's personality (Freud, 1919). Reaching these goals takes a lot of time. In the traditional psychoanalytic therapy, clients have 3–5 sessions per week lasting over several years. Thus, the therapy process is very expensive.

In traditional psychoanalysis the therapist is distanced from the client, both physically (e.g. sitting behind the sofa where the client is laying) and interpersonally (e.g. reveling only little about themselves). In more recent variations of this therapy, the therapist and client sit face to face, but the therapist still remains neutral, like a "blank screen", so the client can project their unconscious attributes and motives onto the therapist. Therapists build the relationship with the clients through empathic responses using reflection of their comments; they use questions and encourage the client to deeply explore his emotions and perceptions (Kramer et al., 2014). Many techniques in psychoanalytic therapy are designed to reveal the nature of unconscious mental processes and conflicts through catharsis and insights.

Free association. In this technique clients are asked to say everything that comes to their mind without censoring to meet social norms. The aim of free association is to help patients recover memories and reveal intrapsychic materials that may be repressed because it is too threatening to bring into consciousness. The therapist's task is to make sense of the emerging pieces that come from the unconscious mind and interpret it for the client (Ursano, Sonnenberg, & Lazar, 2004).

Analysis of transference and countertransference. According to Freud (1912), transference reactions are distortions in the client's reactions to the therapist. The client brings an unconsciously maladaptive pattern of relating into therapy, which

originate from meaningful figures in his or her life, such as parents. These pervasive and maladaptive patterns determine the way the clients react in other relationships, including their relationship with the therapist. The treatment is designed to reveal and analyze those reactions and eventually change them. Countertransference is a phenomenon in which the therapists project some of their own personal issues and feelings onto the patient. Therapists learn how to deal with those emotions during their training.

Analytic interpretation. One of the main techniques in psychoanalysis therapy is suggesting connections between current experience and historically based conflicts to the client. Interpretation is a way of pointing out how the past intrudes on the present. Interpretations can occur during the transference process, through resistance the client might have or feel in session, or through every day behaviors or dreams.

Analysis of dreams. Psychoanalysis views dreams as a way to disclose the uncon-cise ideas and impulses. According to Freud (1900), the content of one's dreams is a symbol of something else, and for each person it can symbolize different impulses or emotions. The patient's dreams may also be considered, as well as his or her ability to think about dreams, as a vehicle for understanding how his or her mind works (Ursano et al., 2004).

Psychodynamic Therapy

Psychoanalysis is still practiced today, but many theorists have advocated changes in Freudian psychoanalysis to employ a related set of new approaches referred to as psychodynamic psychotherapy. The essence of psychodynamic therapy is exploring those aspects of self that are not fully known or understood, especially as they are manifested and potentially influenced in the therapeutic relationship. Conflicts and unconscious processes are still emphasized in each of the psychodynamic methods with efforts made to identify defense mechanisms and hidden emotions, consistent with psychoanalysis therapy. However, psychodynamic therapists use an eclectic mixture of tactics, with a more social and interpersonal focus, that provides more flexibility between interpreting and delivering empathy and emotional support. They involve less emphasis on sexual and aggressive id-impulses, and give more attention to adaptive functioning of the ego and to close relationships. The focus is more on current experience than on childhood and past experiences (Lewis, Dennerstein, & Gibbs, 2008).

Psychodynamic therapy involves less frequent meetings and may be considerably briefer than psychoanalysis proper. Session frequency is typically once or twice per week, and the treatment may be either time limited or open ended. In the late 1970s, short-term psychodynamic approaches were developed (Malan, 1980; Sifneos, 1979; for more details, see Coren, 2001). These approaches were defined as an explicitly time-limited and focused therapy that works by making people aware of emotions,

thoughts and problems with communication/relationships that are related to past and recent trauma (Lewis et al., 2008). Short-term psychodynamic psychotherapy proved to be an effective treatment in some psychiatric disorders (e.g. panic disorder), but less in others (e.g. eating disorders). Larger studies of higher quality and with specific diagnoses are warranted.

The psychodynamic approaches that emerged from psychoanalysis range from minor modifications to comprehensive denunciation of certain fundamental principles of the original theory.

Analytical psychology. Emphasizes the importance of the individual psyche and the personal quest for wholeness. Introduced the concept of the collective unconscious that is stored deep in individual memories and passed down from generation to generation (Jung, 1931).

Individual Psychology. Focuses on the feeling of inferiority and the striving for superiority. The current life of the client is the central focus of this treatment, with the past experiences still taken into account (Adler, 1916).

Ego Psychology. Behavior is determined mostly by the ego, and not by the id. Treatment aims to strengthen the ego so it can better execute reality-testing, impulse-control, judgment, affect tolerance etc. (Erikson, 1964; Freud, 1937; Hartmann & Rapaport, 1958).

Object Relation. Emphasizes the interpersonal relationships that are built early in life. The infant-caregiver relationship is the prototype for later relationships. The therapeutic relationship tries to compensate for the missing parts in the early dyadic relationship and gives the client a new experience of a closer and caring relationship (Fairbairn & Ronald, 1954; Klein, 1935; Mahler, 1952; Winnicott, 1953).

Self-psychology. The self is the core of an individual's psychology. Its development is correlated with the environment. Treatment focuses on empathy toward the client and the exploration of fundamental components of healthy development and growth of the self (Kohut, 1971).

Relational Psychology. The focus is on the relationships the client has in his life, especially with caretakers. In the therapeutic relationship, they emphasize the therapist's subjectivity, which also influences the therapy process (Mitchell, 1993; Stern, 2004).

Support and Critics

The main criticism of psychoanalysis is that it is neither scientifically based nor empirically supported. Nonetheless, a significant fraction of the medical community continues to promote it. Some authors have even built their careers on publishing low-quality meta-analytic reviews in prestigious medical journals by summarizing outdated and poorly conducted single studies in an attempt to demonstrate the effectiveness of psychoanalysis. Unfortunately, much of this controversy is more politically than scientifically motivated. For a current summary of this

debate, see Leichsenring et al. (2015) and Hofmann (2016a, 2016b) in https://www.ncbi.nlm.nih.gov/pubmed/26303562/#comments).

Humanistic and Person-Centered Therapy

The humanistic approach views people as responsible for their lives and actions. In other words, individuals themselves have the freedom and necessary willpower to change their attitudes and behavior. The main psychotherapy that was developed from this approach is a non-directive talk therapy established by Carl Rogers; this approach was called person-centered therapy, and is also known as client-centered or Rogerian therapy (Rogers, 1951). According to Rogers, each person has a tendency to grow and fulfill his or her goals, wishes and desires in life; every person has the potential to grow in a healthy and creative way. For this to happen, a person needs an environment that encourages him/her to be genuine (openness and self-disclosure), accepting (being seen with unconditional positive regard), and empathetic (being listened to and understood). If a person does not have this type of environment (e.g. because of restrictions of parents or society), their capacity to grow might not be fulfilled, and psychopathological symptoms may emerge. Therefore, person-centered therapy centralizes uniqueness, authenticity, striving for appeasement and completion, and acceptance of estranged parts of the person, in order to enable full expression of the personality. This therapy doesn't aim to "cure" people or attempt to help them become "normal," but rather targets personal growth and focuses on improving client's quality of life. Clients are viewed as equals and experts in their own inner world and experiences. Having respect and loyalty for the self are very important as humanistic approach stresses the importance of clients focusing on their immediate and current experiential feelings, as well as the courage a person needs to fully experience his inner world. According to this perspective, the therapeutic relationship is highly important and is characterized by empathy, genuineness and an unconditional positive regard towards the client.

Theoretical Foundation

The core of Rogers' theory is the self, which represents a person's experience and one's set of perceptions and beliefs about oneself. It is influenced by values, images, memories, behaviors and current experiences. The self consists of two parts: the real-self (self-image) and the ideal-self (i.e. who the person would like to be or believe he should be). People strive for greater harmony between the real-self and the ideal-self, which results in a more congruent self and a higher sense of self-worth. The overlap between the real self and the ideal self is represented in the degree to which a person reaches 'self-actualization'. According to Rogers, humans have one basic motive: the tendency to self-actualize, or to fulfill one's potential and

achieve the highest level of functioning. This self-actualization occurs when a person's ideal self is congruent with their real-self.

The self develops in the context of relationships with others, with special attention drawn to the parental relationship. While a person is growing up, he or she realizes which behaviors and self-experiences are encouraged and which aren't. If a child grows up with unconditional positive-regard/unconditional-love, meaning that all of their experiences are accepted by others, they recognize these experiences as part of their real-self. Being valued by others results in a sense of self-worth. On the other hand, if a child experiences rejection or disapproval, and love is only provided under certain conditions when behavior is approved by others, the child will internalize this as conditional self-worth. Understandably, conditional self-worth indicates incongruence between the real-self and ideal-self. Personal growth will then typically be hindered and susceptibility to mental disorders increases (Rogers, 1951, 1959).

By increasing the client's awareness of his or her current experience, person-centered therapy aims to help clients grow authentically in order to experience complete self-actualization. The therapist must create conditions in which clients can discover their self-worth, feel comfortable exploring their identity, and alter behavior to better reflect their identity. Thus, the therapist's goal is to provide the client with a therapeutic relationship that is based on unconditional positive regard and acceptance.

Rogers believed that all people have the potential to change. Therefore, the role of therapists is to foster self-understanding and create an environment where adaptive change is most likely to occur (Rogers, 1951). Therapists who correctly follow this approach assume a non-directive role, and make few interpretations and interjections during therapy. They do not try to change patients' thoughts or behaviors directly or raise topics of discussion. Rather, they use the therapeutic relationship as a platform for personal growth in an atmosphere of unconditional acceptance, genuineness, and warmth. This gives the client a chance to develop self-actualization without interrupting the self.

Therapy Techniques

Because of the extremely non-directive attitude from the therapist towards client's self-discovery, therapy sessions are fairly unstructured. This creates an environment free of approval or disapproval, where clients come to appreciate their own values and behave in ways that are consistent with their own identity.

In order to help clients to grow and reach self-actualization, the therapist uses three interrelated attitudes: (1) unconditional positive regard: by listening to the client, accepting them, and trusting their ability to grow, the therapist makes the client feel valued and free to be as they wish to be; (2) empathy: using reflection to view the world through the client's eyes and help the client feel more understood. Reflection is a process in which the therapist continually restates what the client has said and therefore shows complete acceptance. This allows the client to recognize

their negative feelings; (3) congruence: the therapist earns the client's trust by being honest and consistent with his or her reactions.

Support and Critics

Person-centered therapy can be highly attractive to clients as they tend to find the supportive, flexible environment of this approach very rewarding. Research on Rogers's core conditions emphasizes the importance of empathy, unconditional positive regard, and congruence to promote progress in therapy. Even though relatively few therapists today describe themselves as primarily person-centered in their orientation, the principles of this approach permeate the practice of many, if not most therapists. Various schools of psychotherapy are increasingly recognizing the importance of the therapeutic relationship as a means to therapeutic change (Kirschenbaum & Jourdan, 2005). The main disadvantage of person-center therapy is that the empirical findings on its effectiveness are inconsistent. This is possibly because the treatment is primarily based on *unspecific treatment factors* (e.g., establishing a good relationship with the patient) without considering *specific treatment factors* to directly target mental problems (Cuijpers et al., 2012; Friedli, King, Lloyd, & Horder, 1997). Further research is necessary to evaluate its utility as a therapeutic approach.

Systemic Therapy

Systemic approaches were developed in the United States of America in the 1950s. After World War II research began focusing more on groups and communities and interactions within them. One of the most influential researchers during this period was anthropologist Gregory Bateson, who together with Jay Haley, John Weakland, and Donald Jackson (Bateson, Jackson, Haley, & Weakland, 1962), studied patterns of family interactions, which laid the groundwork for family-based treatment. This approach eschewed the traditional focus on individual psychology and instead emphasized that individuals should be understood within their social context.

With influences from the General Systems Theory in biology and physiology as well as cybernetics in computer sciences, systemic psychotherapy began to view the individual as a part of a bigger system. A system is defined as a set of units that stand in a consistent relationship with one another. When applied to systemic psychotherapy, a system could be a family, a partner relationship, or even a close-knit community. For a system to function effectively, it requires methods and rules to maintain stability. However, a system must also be dynamic and allow movements inside and among its units/members. Thus, a system needs to have balanced boundaries between its members where individual members know their differentiating roles (e.g., a child and a parent), but can communicate openly to relay and

receive information. Together, these components help maintain a flexible and malleable dynamic in the system.

Nowadays systemic therapy is synonymous with relation or family therapy. The family (or partner relationship) is considered the system and one family member (or one partner) is considered one unit of that system. The independent units are tied together either biologically, emotionally, legally, historically, or geographically (Carr, 2009). The different units within a system are interdependent and connected via positive and negative feedback loops. In essence, if one member of the system is not functioning well, the entire system is affected. On the other hand, one member of the system can also strengthen the entire system. According to systemic therapy, problems in humans originate from interpersonal difficulties. So, in order to understand an individual, the relationships around him or her also have to be examined (Prochaska & Norcross, 2014).

There are several different schools of therapy that utilize the systemic approach. Each type of systemic therapy has its unique way of conceptualizing problems and developing a treatment plan in support of the therapy goals.

Structural therapy. Was developed by Salvador Minuchin (1974) and Minuchin and Fishman (1981). As its name suggests, instead of focusing on the pathological symptoms of a person (unit in a system), structural therapy targets the structure of the system. Alleviating the problems in family relationships will in-turn relieve the symptoms of one or more of its members. Balancing stability and flexibility in relationships (alliances, coalitions, hierarchies, generation conflicts, etc.) is important to reduce the pathological symptoms in one (or more) of the members. For example, if a child experiences frequent tantrums, structural therapy will examine the structure of the family to solve any inter-relational problems and reduce or completely eliminate the child's tantrums.

Communication/Strategic therapy. Jay Haley and Watzlawick are important figures in Communication/Strategic therapy, which observes patterns of communication within the system. Strategic therapy adds communication theory to the systemic therapy. Watzlawick, Beavin, and Jackson (2011) described a number of ground rules for communication in systems. According to this orientation, members of a system can only be understood if the rules and processes within their system are transparent and well-communicated. If communication patterns are not clear, ambiguity is likely to lead to psychopathology.

Intergenerational/Bowen family therapy. This approach was developed by Murray Bowen (1978), one of the family therapy's founders. Bowen's approach observes family behaviors through the lens of intergeneration. According to him, a family's history shapes the values, thoughts, and experiences of each generation, and influences how these values are passed down to the next generation. Thus, each problem in a family is a product of intergenerational developmental processes. In his model Bowen introduced eight interlocking concepts to explain family development and functioning (e.g. differentiation of the self, triangles, the nuclear family emotional process, etc.). One of Bowen's main ideas emphasizes the necessary balance of two forces—togetherness and individuality. An excess of togetherness creates fusion between family members and prevents individuality (i.e. developing the individuals' unique sense of

self). Whereas an excess of individuality results in a distant and estranged family. Thus, an equal balance of togetherness and individuality occurs when individuals differentiate themselves from the family, which means that they have their own opinions and values, but are also emotionally connected to the family.

The goal of systemic therapy is to improve the function of the system by shifting dynamics of current relationships. The therapist aims to increase members' awareness of the function of the system as well as how the system influences and is influenced by each individual.

Structural therapists focus on the person within the family context. They aim to help the family conceptualize symptoms as systemic problems rather than individual disorders. Once the alliance is established, the therapist takes a role of a leader that advocates for the benefit of each member against the destructive structure of the system. *Strategic* therapists aim to develop an atmosphere conducive to more congruent and functional communication in the system. The *Bowenian* therapists' role is remain an objective and not emotionally involved member within the system. They act as a model of autonomy, which helps family members understand how they should behave, and they promote awareness of the intergeneration influence, which helps members understand their overarching family dynamic.

Therapy Techniques

Therapists who are more *structural* in orientation employ activities such as role play in session, and encourage the system's members to engage in particular activities (e.g. ask a mother to talk with her son about a specific topic and come to a decision). This helps the members to experience their reaction with heightened awareness. *Strategic* therapists reflect empathy, caring and congruency to the system's members in order to create an open atmosphere that promotes the communication among the system's members. They also direct members' behaviors and inform members of what to do differently in order to improve the communication. *Bowenian* therapists begin with a family evaluation and a construction of a family genogram to understand and emphasize the intergeneration role in current family behaviors. In addition, they encourage family members to respond with "I" statements rather than accusatory statements to increase members' differentiation.

Support and Critics

Many different studies and meta-analyses found systemic therapy to be effective (Stratton et al., 2015). It is significantly more efficacious than control groups without a psychosocial intervention, and equally or more efficacious than other evidence based interventions (e.g., CBT, family psychoeducation, or antidepressant/neuroleptic medication) (Von Sydow, Beher, Schweitzer, & Retzlaff, 2010). Systemic therapy was found to be efficacious in different age ranges (Retzlaff, Von Sydow,

Beher, Haun, & Schweitzer, 2013), and with different diagnoses, such as affective disorders, eating disorders, substance use disorders, psychosocial factors related to medical conditions, and schizophrenia (Prochaska & Norcross, 2014; Stratton et al., 2015; Von Sydow et al., 2010).

Critics of the systemic therapy claim that this approach is not able to adequately describe an individual's responsibility. For example, if a system member is violent, this treatment would move away from that violent individual and emphasize system interactions, which ignores the morality of this unacceptable behavior (Spronck & Compernolle, 1997). Others think that systemic therapy is over simplified and unable to address more severe psychopathologies, which require more specialized attention. The Bowen therapy was criticized for trying to crossbreed the psychoanalytic approach and the systemic approach in a way that did not effectively emphasize the individual or the system, but instead focused on a vague combination of the two (Prochaska & Norcross, 2014).

Conclusion

Psychotherapy approaches, methods and techniques have been altered and expanded over the years. Since the beginning of the last century, several schools of thought have emerged for the treatment of mental health problems. In addition to the orientations discussed in this chapter, there are other, less practiced, methods for psychotherapy (e.g., Existential therapy, Gestalt therapy, Interpersonal therapy), that view human nature and the way to change psychopathology through different perspectives.

CBT has the most empirical support, and many therapists conduct therapy according to this therapeutic orientation (Kramer et al., 2014). Recent advances focus on therapeutic processes rather than techniques for DSM-defined syndromes (Hayes & Hofmann, 2017). Other developments in research and technology allow clinicians to disseminate treatments that are effective in treating symptoms of psychopathology. For example, in recent years, treatments delivered through the internet, mobile phones, and computers are increasingly gaining attention and popularity in research and practice (e.g. online CBT, attention/cognitive bias modification, etc.) (Frazier et al., 2016; Price et al., 2016). The primary goal of this dissemination is to reach as many people as possible with effective therapy techniques that can improve people's lives regardless of symptomatology.

Although each psychotherapy approach has its own models and methods, and clinical training typically consists of just one of the many models, today more and more clinicians (between 13 and 42%) identify their own approach as integrative or eclectic. Psychotherapy Integration uses the perspectives and techniques of different schools of psychology rather than rigidly adhering to one. (Norcross & Goldfired, 2005). However, the most important development in the field of psychotherapy is arguably the shift from single therapy schools and DSM-defined treatment approaches toward understanding the processes through which therapeutic change

occurs. This is in line with a general move toward transdiagnostic approaches, as well as personalized and precision medicine. Future research will better allow the field to understand which therapeutic techniques work for which individuals under which context and why. The future of psychotherapy research is likely to gain insight from cognitive, behavioral, social, affective, emotion, and neuro-sciences.

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North America

Elaine S. Lavin and Lata K. McGinn

Introduction

Clinical psychology as a discipline and a profession in North America has rapidly evolved in its 125-year history. A discipline that was originally academic has broadened to include both research and clinical work with substantially more psychologists employed as clinicians than researchers. Whereas most of the early clinical functions performed by psychologists were related only to assessment, psychotherapy is now the primary clinical role of psychologists. The dominant theoretical orientation has shifted from psychodynamic to cognitive behavioral. Training has become more regulated and standardized, while evolving to create a variety of models aimed at training clinical psychologists in accordance with their career goals. Efforts have been made to increase the role of research findings in clinical practice. Regulations from state governments and evolving common law have reshaped psychologists' obligations to their patients in regard to confidentiality. Changes in healthcare systems, insurance practices, and government and economic incentives have reshaped clinical practice. Psychologists have expanded beyond the laboratory and traditional clinical practice to take on wider roles in healthcare, education, business, and a broad array of arenas in American and Canadian life. These expanding roles and the wide range of career possibilities makes it a particularly exciting time to be a clinical psychologist.

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History

The broader field of psychology in the United States began primarily as an academic discipline with William James who founded the first psychology laboratory at Harvard University in 1861. Lightner Witmer, was the first psychologist to use the term "clinical psychology," and to apply his scientific understanding of cognition and behavior with the goal of helping an individual with a specific problem (Benjamin, 2005; Routh, 2011). A professor at the University of Pennsylvania, Witmer was asked to help a grammar school student who had difficulty with spelling. Witmer adapted many of his laboratory procedures to assess the boy and the remediation strategies he devised and applied as a result of the assessment were deemed successful. In 1896, he founded the first psychology clinic, which eventually came to include Ph.D. students in psychology and a social worker on its staff.

Though Witmer's clinic included both assessment and treatment of school-related difficulties, prior to World War II, clinical psychologists largely applied their research to assessment as opposed to treatment. In the first decade of the 1900s, psychologist Alfred Binet and physician Theodore Simon developed an intelligence test in France that was found to correlate with school performance. American psychologist Henry Goddard, the director of psychological research at the Vineland School in New Jersey, arranged for this test to be translated into English and validated its ability to diagnose intellectual disability in children (Zenderland, 1998). The test became known as the "Stanford Binet" and administration and scoring of psychological tests quickly became the primary activity of clinical psychologists in the United States. During World War I, the army employed psychologists to develop psychological tests to select soldiers for various military occupations and to screen out recruits deemed unfit for military service. This work received favorable publicity and improved the status of the field.

World War II had a major impact on the field of clinical psychology. Psychologists working with the military expanded psychological testing to include advances in cognitive testing and personality testing. It also led to a large-scale expansion of psychologists in the role of treatment provider. Psychiatrists had long opposed having psychologists in this role and many psychologists considered psychoanalysis, the most widely practiced treatment, to lack a scientific basis (Benjamin, 2005). However in the 1940s, aware that large numbers of returning veterans would likely require psychological services and that there were not enough psychiatrists to fill that need, the Veterans Administration (VA) and United States Public Health Service began to direct funds to expand clinically-focused training within clinical psychology. The VA became and remains one of the largest single providers of internship training and employment for clinical psychologists (Zeiss & Karlin, 2011).

Training

As part of this rapid expansion, it became clear that a standard training model for clinical psychology was needed. In 1947 the American Psychological Association (APA) began to set training guidelines, including the requirement that clinical

psychologists be trained as both scientists and professionals and earn a doctoral degree (APA, 1947). With support from the National Institute of Mental Health, representatives from psychology graduate programs came together in 1949 to establish a training model that became known as the Boulder or scientist-practitioner model. This model includes training in core clinical skills, practicum experience during graduate training, a yearlong internship, and research training including a dissertation (Benjamin, 2005) and results in a Doctor of Philosophy (Ph.D.) in Clinical Psychology degree. The Practitioner-Scholar model was formulated at a conference in Vail, Colorado in 1973 in order to prepare graduates for a career in professional practice informed by science, which led to the creation of the Doctor of Psychology (Psy.D.) degree (Peterson, 1976). This model includes the same main components of the Boulder model, but places greater emphasis on preparation for professional practice, including the ability to integrate and apply scientific literature to clinical work.

In practice, Ph.D. and Psy.D. programs fall on a continuum in their emphases on research and clinical training (Norcross & Sayette, 2012), with some Ph.D. programs primarily offering research training, some Psy.D. programs focusing heavily on clinical practice, and many programs of both types offering similar levels of research and clinical training with only slightly different emphases. There has been a substantial increase in the number of students training in clinical psychology and the number of training programs over the last 50 years. Sadly, there has also been a significant proliferation of lesser quality programs, largely for-profit, that offer weaker training in both research and practice.

The clinical science model proposed by Richard McFall in 1991 focuses on training in research and the application of scientific research to practice (Baker, McFall, & Shoham, 2008). A growing number of the programs adhering to this model explicitly discourage applicants who are exclusively interested in clinical practice (Barlow, 2011). The APA accredits programs from all three models, and there are currently 237 accredited clinical psychology doctoral programs in addition to related programs in counseling and school psychology (APA, n.d.a). In 2009, the Psychological Clinical Science Accreditation System began with the goals of accrediting clinical science programs (PCSAS, 2015) and of ensuring tight quality control over these programs. The PCSAS accreditation is intended to ensure that future generations of clinical psychologists contribute to advancing public health by enhancing scientific knowledge in mental health, and uses 50% success in placement of graduates in research careers as a requirement for programs to receive accreditation through this model.

However, an accreditation system that promotes only one model of training creates a risk of division in a field that may be better served by unified efforts to promote high quality clinical psychology research and clinical training, ensure the continued integration of science and practice, inhibit the growth of poor quality programs, secure financial resources to promote research and training, and provide the public with a clear and distinct identity for clinical psychology from other mental health disciplines.

Interestingly, as the PCSAS accreditation system moves away from practice and towards an exclusive focus on research training and careers, the APA's new Standards of Accreditation (SoA) replaces the term "professional psychology" with the term

"Health Service Psychology," firmly establishing clinical psychology as an applied discipline in line with other health service disciplines (APA, 2015). Also, in contrast to PCSAS's emphasis on a single model of training, APA's Council of Accreditation (CoA) no longer recognizes models of training or evaluates programs based on adherence to models of training and distinguishes programs based only on the degrees offered (Ph.D. or Psy.D.). Although the new Standards of Accreditation developed by the Council of Accreditation represent improvements on the earlier Guidelines and Principles for Accreditation (G&P) and have the stated goal of "providing greater clarity to the public and enhanced opportunities for innovation in health service psychology education and training," these and other recent improvements may be too late to stem the tide against the move to an alternative accreditation system.

One major challenge currently facing clinical psychology training in the United States is the imbalance between the number of available internships and the number of graduate students seeking them. Students are required to complete the equivalent of a yearlong full time internship to get their doctoral degrees. These internships are obtained through a national matching process sponsored by the Association of Psychology Postdoctoral and Internship Centers (APPIC). In 2015 only 83.8% of students in American clinical programs seeking an internship were matched through the APPIC system, leaving 368 students to seek internships outside the system or seek to improve their qualifications and reapply the following year (APPIC, 2015). Typically, a significantly larger percentage of students enrolled in freestanding, for-profit schools offering a Psy.D. degree fail to obtain internships through the APPIC match than students in Psy.D. or Ph.D. programs affiliated with universities (Norcross, Ellis, & Sayette, 2010), and this percentage is even larger for non-APA accredited programs (Anderson, 2009). Individual graduate programs also have widely varying internship match rates, and 15 programs (14 of them APA accredited), generate a disproportionate percentage of unmatched applicants, have higher admissions acceptance rates, and grant degrees to students who obtain lower scores on the Examination for the Professional Practice of Psychology (EPPP; Norcross, Castle, Sayette, & Mayne, 2004; Peterson, 2003; Ross, Holzman, Handal, & Gilner, 1991; Yu et al., 1997), leading for calls by some to focus reform efforts on these programs (Parent & Williamson, 2010). Proposals to improve the match rate have also been made at a broader systemic level and include increased support for developing and accrediting new internships, advocating for increased government funding for psychology training, and limiting the APICC match to students in APA accredited training programs (Anderson, 2009; CCTC, 2012). Recent efforts by the APA and other funding agencies (e.g., Health Resources and Services Administration) have led to a decline in the internship imbalance, although more efforts are needed to fully address the problem.

Clinical psychology as a field developed more slowly in Canada than the United States. Prior to World War II, there were fewer than 100 clinical psychologists in Canada and they were primarily academics (Conway, 1984). Professional training was slower to expand following the war than it was in the United States and was largely at the master's level. Clinical psychology programs in English-speaking Canada were more likely to adopt the scientist-practitioner model with a heavy emphasis on scientific research and the awarding of doctoral degrees, whereas programs in French-speaking Canada were more practice oriented, had larger

enrollments than programs in the rest of Canada, and were more likely to award masters degrees (Conway, 1984). Many Canadian doctoral programs sought and received accreditation from the APA (MacKay & Dobson, 2009). Founded in 1938, the Canadian Psychological Association was not formally organized until 1939. Clinical training standards in general were slower to develop in Canada, in part because of its scientific focus, with the Canadian Psychological Association (CPA) not adopting accreditation criteria for doctoral training until 1984. For many years Canadian programs maintained both APA and CPA accreditation. As of 2015 the APA no longer accredits programs in Canada, but the APA and CPA recognize each other's accreditation as equivalent (APA & CPA, 2012).

Regulation

In 1947, Connecticut became the first state to regulate the practice of psychology with the implementation of requirements for licensure. Since then, each state has developed its own licensing requirements, and today only psychologists who have completed state licensing requirements can practice independently. Most states require the completion of 1–2 years of postdoctoral training before psychologists can take the written Examination for Professional Practice in Psychology (EPPP), the exam used by all states. Some states require an additional oral exam or essay. Once licensed, some states require psychologists to obtain a certain number of continuing education credits before their license can be renewed. Because licenses are issued at the state level, psychologists are not automatically qualified to practice if they move across state lines.

Canada also has provincial and territorial as opposed to federal level licensing of psychologists. Unlike the United States, it has a long history of individuals with Masters degrees practicing with the title of "psychologist." In the past 30 years, some provinces have shifted from requiring a master's to a doctoral degree, and others have created the title of "psychological associate" for those with master's degrees (Hunsley, Ronson, & Cohen, 2013). Many provinces and territories also require the EPPP. Canadian psychologists now have greater mobility between jurisdictions than American psychologists. Canada's 1994 *Agreement on Internal Trade* (AIT), which aimed to increase mobility of goods and workers in Canada, provided the impetus for the CPA and other professional psychology organizations to develop the *Mutual Recognition Agreement* (MRA; Gauthier, 2002). Signed by psychology regulatory bodies in 2001, it requires core competencies for those providing psychological services, regardless of their jurisdiction or title, and allows most psychologists who are licensed or registered in one jurisdiction to practice in another without further education or evaluation.

Professional Roles and Settings

Clinical psychologists serve in a wide range of professional roles and most psychologists in the United States perform more than one role. Psychotherapy is the

predominant activity: a 2010 survey of members of the Society of Clinical Psychology, APA Division 12, found that 76% reported conducting psychotherapy for an average of 35% of their professional time (Norcross & Karpiak, 2012). Of those who reported practicing psychotherapy, almost all reported practicing individual therapy, about half reported practicing couples therapy, but significantly fewer indicated practicing family or group therapy. The same survey found that 58% of Division 12 psychologists reported being routinely involved in assessment or diagnosis. Formal psychological assessment remains a distinctive aspect of clinical psychology: while many allied mental health professions conduct psychotherapy, only psychologists are qualified to conduct formal assessment. In addition, about half of the psychologists surveyed reported involvement in teaching, supervision, research/writing, or administration (Norcross & Karpiak, 2012). Many psychologists also serve as consultants in a variety of forms including providing guidance to colleagues or other health professionals on their patients, advising organizations on ways to manage interpersonal and organizational conflicts, and serving as coaches to executives with the goal of helping them become better leaders. Though psychologists serve in a wide range of roles, most graduate programs only directly train students in research and clinical practice. Skills needed for consulting, administrative, and supervisory roles tend to be learned in the process of serving in those roles. Most psychologists serve in more than one of the above mentioned roles, though overall participation in a broad range of roles has declined, likely indicating an increase in specialization with more time spent engaged in fewer roles (Norcross & Karpiak, 2012).

Clinical psychologists also work in a wide range of settings. In the United States, 41% of psychologists reported being primarily employed in private practice in the 2010 APA Division 12 survey, an increase of more than 100% since 1960 (Norcross & Karpiak, 2012). Of those not employed full-time in private practice, 50% reported private practice work on a part-time basis. Other clinical employment settings for psychologists include both psychiatric and general hospitals, outpatient clinics, and the VA health system. Clinical psychologists in these settings frequently collaborate with allied health professionals such as psychiatrists, social workers, nurses, and medical doctors focused on physical health. In addition many psychologists are employed in university academic departments (both psychology and other disciplines) and medical schools. Some of these psychologists do not engage in clinical work and some do not even seek licensure. The 2010 APA Division 12 survey found that 60% of respondents identified primarily as clinical practitioners, 18% as academicians, 10% as researchers, and 6% as administrators (Norcross & Karpiak, 2012). There appears to be a trend towards clinical psychologists being employed in single positions: a similar survey in 1960 found that fewer than one-third reported being employed in a single position whereas in 2010, 50% reported being employed in a single position and only 8% reported engaging in three or more positions (Norcross & Karpiak, 2012). In addition, clinical psychologists under fifty were much less likely to report being primarily employed in private practice in the 2010 survey (Norcross & Karpiak, 2012); this may reflect a general trend away from private practice or varying employment choices at different stages of psychologists' careers. This survey found a higher average age of Division 12 members than previous surveys, which may be

reflective of younger psychologists being less likely to join Division 12. It should be noted that though this survey provides useful information on the distribution of psychologist employment and other areas of interest, the data many not be an accurate reflection of the overall population of clinical psychologists in the United States, as many are not members of Division 12.

In a 2009 Canadian survey designed to be representative of psychologists across the nation, 77% of psychologists reported being engaged in some private practice, with 36% reporting being engaged primarily or exclusively in private practice (Hunsley et al., 2013). Practitioners in the public sector were more likely to teach or be engaged in research than those in the private sector. Doctoral level clinicians were more likely to spend more time on assessment and be more involved in consulting roles than master's level clinicians who devoted a larger share of their time to intervention. It should be noted that this survey included clinical, counseling, school and neuropsychologists.

Theoretical Orientation

Predominant theoretical orientations have shifted over the last 50 years. In the 2010 Division 12 survey as in surveys in years past, respondents were given a list and asked to choose their primary and secondary theoretical orientation (Norcross & Karpiak, 2012). In 2010, the most popular choice was cognitive (31%), followed by eclecticism/integration (22%), psychodynamic (18%) and behavioral (15%) and smaller percentages for interpersonal, Rogerian, systems, and constructivist. This study may underrepresent the use of cognitive theory and techniques: Norcross, Karpiak and Lister (2005) surveyed those who identified as integrationist or eclectic in a 2003 Division 12 survey and found that cognitive therapy was the largest contributor to these clinicians' practice. This reflects a trend of overall increasing identification with a cognitive behavioral orientation and declining psychodynamic identification since 1960. This trend is also reflected in the demographics of those surveyed: those ages 65 and below were significantly more likely to endorse a cognitive behavioral orientation and less likely to endorse a psychodynamic orientation than those above the age of 65. The trend is starker in Canada: in the 2009 survey, which allowed for the selection of more than one theoretical orientation, 80% selected cognitive-behavioral, 31% humanistic/experiential, 26% psychodynamic, 23% interpersonal, and 21% family systems (Hunsley et al., 2013). Both these studies only assessed self-identified theoretical orientation; many psychologists may practice in a manner that strict adherents of an orientation would not consider to be congruent with that orientation (Waller, Stringer, & Meyer, 2012). A survey of practicing APA members (including counseling and school psychologists) found that most of them endorsed using techniques outside their direct theoretical orientation (Thoma & Cecero, 2009) and a study of master-clinicians found only small differences between clinicians of different theoretical orientations in clinician-identified clinically significant portions of sessions (Goldfried, Raue, & Castonguay, 1998). Though there is likely a strong trend toward an increase in the use of cognitive behavior theory and techniques over the past 50 years, the picture of how clinicians actually practice is more complicated.

Integrating Research and Practice

A major development in the landscape of clinical training and practice is the concept of evidence-based practice (EBP), defined as integrating the best available research with clinical expertise and patient values (American Psychological Association, Presidential Task Force on Evidence-Based Practice, 2006). Based on initial efforts in the field of medicine (Evidence-Based Medicine Working Group, 1992; Sackett, 1969; Sackett, Haynes, & Tugwell, 1985; Sackett, Haybes, Guyatt, & Tugwell, 1991) and later within Clinical Psychology (Chambless et al., 1996, 1998), this model was officially endorsed by the APA in 2005 (American Psychological Association, Presidential Task Force on Evidence-Based Practice, 2006). In addition, the VA, Medicare, Medicaid, and private insurance companies have begun to take EBP into account in policy deliberations and reimbursement decisions (Spring, 2007).

To the extent to which EBP is controversial, much of the debate appears to be centered over how the three aspects are balanced, with researchers generally advocating a heavier reliance on research evidence than clinical expertise. Though surveys have shown general positive attitudes toward EBP among clinicians (Lilienfeld, Ritschel, Lynn, Cautin, & Latzman, 2013), many clinicians report relying on clinical expertise over empirically supported treatment literature in making clinical decisions (Safran, Abreu, Ogilvie, & DeMaria, 2011; Stewart & Chambless, 2007). The gap between psychotherapy research and practice is also evident in clinical training: a 2006 survey found that 44% of Ph.D. and 67% of Psy.D. programs in clinical psychology did not offer both clinical supervision and didactic training in evidence-based treatments (Weissman et al., 2006). Using principles of evidence-based training in medicine, Beck and colleagues have proposed a model for improving clinical training in EBP that formally integrates experiential and didactic teaching/supervisory methods to teach students the requisite skills to base clinical practice on research, use critical thinking, and engage in lifelong learning (see Beck et al., 2014 for a complete review).

Ethics and Legal Issues

Communications between patients and their psychotherapists are considered privileged in the United States. Usually, the psychotherapist is only permitted to release information to a third party with written permission from the patient. What information can and must be disclosed without permission varies from jurisdiction to jurisdiction. Common circumstances in which the therapist is mandated to break confidentiality include the patient being likely to harm himself, threats made against specific individuals, and ongoing child abuse. In 2013, following the deaths of 28 individuals in the Sandy Hook Elementary School shooting commited by a lone gunman with a history of mental illness, New York expanded mandated reporting requirements with the Secure Ammunition and Firearms Enforcement (SAFE) Act.

This legislation requires that certain mental health professionals including clinical psychologists provide identifying (but not clinical) information to county mental health officials if they believe it is likely that one of their patients will harm themselves or someone else (Eells, 2013). This information will then be used to determine if the patient should be prevented from purchasing firearms or if the patient has a firearm that should be removed. These mental health professionals are protected from criminal and civil liability for choosing to report or not report, which may serve to limit the impact of the provision. Though this legislation has the potential to remove weapons from those who might harm themselves or others, it infringes on mental health professionals' primary duty to care for their patients and provides reason for increased reluctance among patients to report suicidal or homicidal ideation.

Both the APA and CPA have ethics codes to which they expect their members to adhere, in addition to abiding by the legal requirements in their jurisdictions. In the United States and Canada ethics complaints can be handled by bringing the complaint to the APA/CPA (though the CPA rarely receives complaints), licensing boards, or through private lawsuits. Pope (2011) found that dual relationships with patients (sexual or non-sexual), unethical, unprofessional or negligent practice, criminal conviction, and improper record keeping are the most common reasons that licensing boards in the United States take disciplinary action. The reasons are similar in Canada, though breach of confidentiality is more common than criminal conviction. Professional liability suits appear to be more common in the United States than Canada, and in a 10-year period the largest percentage of claims were paid out for ineffective treatment or failure to appropriately consult or refer, improper diagnosis or failure to diagnose, child custody disputes, and sexual misconduct (Pope, 2011). All clinical psychologists in the United States are required to carry malpractice insurance. In the United States, there is a large emphasis on the legal aspects of maintaining confidentiality and other ethical concerns, sometimes to the point of focusing on protecting the psychologist as opposed to the patient (Fisher, 2008).

Future Directions

The field of clinical psychology continues to rapidly change. Demographically, the proportion of female clinical psychologists is rapidly increasing, and will continue to do so based on the demographics of students currently enrolled in doctoral programs (Hunsley et al., 2013; Norcross & Karpiak, 2012). In addition, ethnic minorities make up a larger portion of clinical psychologists than in the past 50 years, but this increase still lags behind the proportions of ethnic minority populations in the United States and Canada, and has fallen short of the APA's goal to increase ethnic minority representation in the field (Grus, 2011; Hunsley et al., 2013; Norcross & Karpiak, 2012). The continued feminization of the profession will require the field to both anticipate and accommodate the special needs of women in order to maintain them within the workforce while enhancing efforts to increase the enrollment of men and ethnic minorities into clinical psychology graduate programs.

A significant number of challenges lay head and in many ways the field of clinical psychology is at a crossroads. Dissatisfaction with APA's accreditation system served as an impetus for the development of the alternative PCSAS accreditation system intended to better facilitate the advancement of science. However, this new accreditation system inadvertently creates a needless wedge between science and practice, and as a result, among high quality scientist-practitioner programs that value the integration of both. Without a reasoned dialogue and unity between both sides to approach problems facing our field, the fissure between science and practice may widen over time and further weaken the field. Similar to the division between bench research (Ph.D.) and clinical practice (M.D.) in the biological sciences, the field of clinical psychology may also separate and develop two distinct identities over time, one focused on basic research and the other on clinical practice.

The unity of the field is now a more pressing goal than ever. The identity of the profession faces considerable pressure from other professions and from developments in the field. The Research Domain Criteria (RDoC) released by the National Institute of Mental Health (NIMH) in 2008 may be one such example. This new classification framework for research on mental disorders is intended to integrate many levels of information to better understand basic dimensions of functioning underlying the full range of normal and abnormal human behavior. Thus, the RDoC project has the potential to dramatically increase our understanding of mental disorders and their treatments and offer opportunities for greater integration between disciplines for the betterment of mental health. However, the RDoC places a far greater value on the contributions of genomics and neuroscience over behavioral science, a value that is reflected both in the philosophy and funding decisions of the NIMH. The dearth of funding for pure behavioral science research has led many behavioral scientists to be excluded from funding opportunities. Others have coped by incorporating genomics and neuroscience into their own research program, which could potentially diminish and devalue the scientific contributions of behavioral research over time.

There are many changes afoot on the clinical front as well. Changes in insurance coverage for psychological services have historically had and will continue to have major impacts on the practice of clinical psychology in both the United States and Canada. Initially, clinical psychologists in the United States could not be reimbursed for their services by medical insurance companies because they lacked medical degrees. Lobbying efforts by psychologists in the 1970s prompted state legislatures to pass "freedom-of-choice" laws allowing anyone licensed to practice mental healthcare to be reimbursed; clinical psychologists can now be reimbursed for psychological services in all 50 states. For 10–20 years, psychologists could treat their patients as they saw fit and expected to be at least partially reimbursed by the patient's medical insurance if it included mental health coverage, with the patient paying the remainder of the fee. This model began to falter in the 1980s with the development and spread of managed health care, some form of which covered half of Americans as of 2006 (Cantor & Fuentes, 2008). Managed healthcare has interfered with therapists' practice by limiting the number of sessions patients can receive, reviewing therapy notes and treatment plans to authorize the

continuation of care (utilization review), requiring primary care doctors to authorize referrals to psychologists, reducing inpatient stays, and limiting reimbursement rates, among other tactics designed to minimize costs to the insurers. Many therapists consider working with managed care companies the most stressful aspect of their job (Rupert & Baird, 2004). Some therapists have responded by offering briefer models of psychotherapy, while others have opted out of the managed care system and do not directly work with any third party insurers. Therapists who have opted out of working with third party insurers are more likely to have more experience, creating inequities in access to quality mental healthcare (La Roche & Turner, 2002).

Large-scale changes in coverage and potentially of access to mental health care in the United States are underway through a combination of the 2008 Mental Health Parity and Addiction Equity Act (MHPAEA) and the 2010 Patient Protection and Affordable Care Act (PPACA; Beck et al., 2014). Mental health parity is the requirement that health insurance policies do not impose quantitative (e.g. session limits, total spending limits) or qualitative (e.g. size and scope of provider network, utilization reviews) limits on mental healthcare coverage beyond those imposed on medical/surgical coverage. The Affordable Care Act is aimed at reducing disparities, increasing prevention and wellness initiatives, and is intended to promote health care efficiency by measurement and tracking of healthcare outcomes. The combination of MHPAEA and the ACA is expected to extend coverage for mental health and substance use disorder treatment to 30 million Americans who previously lacked this coverage, enhance behavioral health coverage for an additional 30 million individuals who already had some form of coverage, and make providers more efficient and accountable for healthcare outcomes (Beck et al., 2014; Beronio, Glied, & Frank, 2014).

Many of the coverage-expanding provisions in the ACA took effect in 2014 and it remains to be seen how these changes will impact access and utilization of services. An APA survey conducted in March 2014 found that substantial portions of Americans said that their health insurance had different limits or copayments for behavioral healthcare (mental health and substance use care) and slightly less than half of those surveyed stated that their current health insurance covered visits to a psychologist (APA, 2014). Some of these results may be attributed to a genuine lack of coverage because even though the ACA requires most health insurance plans to cover behavioral healthcare, some workplaces and some grandfathered plans are not required to provide such coverage. However, a larger share of these responses is likely accounted for by healthcare consumers' lack of knowledge of their rights and the terms of their plans. Hopefully more Americans will become more aware of their coverage and rights as the time since implementation of the ACA increases.

Even with full implementation of the ACA, there will be Americans who do not functionally have access to the behavioral healthcare they need. Much of the expanded coverage is in the form of insurance plans with high deductibles, and some workplaces are transitioning to such plans, impacting those who have maintained insurance coverage prior to the ACA. (Saper, 2015; Wharam, Ross-Degnan,

& Rosenthal, 2013). High deductibles serve as a barrier to using healthcare for Americans with limited financial resources because they require paying for large portions of their medical services until the deductible is met for the year. There will continue to be a need for states to maintain public mental health systems to provide services not or only partially covered by traditional health insurance. These services are particularly critical for the care of severely and persistently mentally ill individuals and those experiencing first episode psychosis. They include supportive housing, employment and education, family psychoeducation, long-term institutional care, Assertive Community Treatment, and therapeutic foster care (Goldman & Karakus, 2014; Kane et al., 2015). Public mental health systems will also continue to be necessary to serve those not covered by the ACA such as undocumented immigrants, those who elect not to take insurance coverage, and individuals with insurance coverage that cannot afford to use their insurance due to high deductibles (Goldman & Karakus, 2014; Wharam et al., 2013).

The role of psychologists in the broader American healthcare system is also evolving. Though there will likely to continue to be clinical psychologists working in private practice for the foreseeable future, more psychologists provide services in settings that integrate medical and behavioral health in primary care and community health centers that offer services to underserved communities. Twenty to twenty-five percent of patients presenting in a primary care setting have a comorbid psychiatric condition (Spitzer, Kroenke, & Williams, 1999); these conditions have a major impact on patient physical health and their use of medical services, and are worthy of treatment in their own right (Simon, VonKorff, & Barlow, 1995). Psychologists in these settings provide traditional services and leverage their skills in psychological assessment to serve as consultants to medical doctors, nurses, social workers, and other members of the healthcare team. In addition to targeting DSM disorders, psychologists, especially those specializing in the growing field of health psychology, provide behavioral interventions targeting diet, medication compliance, and substance use. The ACA provides incentives for the creation of integrated healthcare centers and the organization of health homes to manage and coordinate the care of severely mentally ill patients and those with multiple chronic physical conditions (Katon & Unutzer, 2013; Mechanic, 2012). Integrated care has the potential to enhance physical and mental healthcare outcomes for a wide range of patients, and expand the role of psychologists in the broader medical system.

Another fairly new role for clinical psychologists is the prescription of psychotropic medication. Psychologists currently have prescription privileges in New Mexico, Louisiana, Illinois, and Iowa (APA, 2016; APA, n.d.b). These states require licensed psychologists seeking prescription privileges to complete substantial postdoctoral coursework and supervised training in clinical psychopharmacology. Arguments made by those in favor of prescription privileges include the fact that most psychotropic medications are prescribed by primary care doctors who have little specialized training in mental health (DeLeon & Wiggins, 1996) and that psychologists can provide comprehensive mental health services to meet public health needs. The APA and state psychological organizations in the United States and provincial psychological associations in Canada are currently supporting lobbying efforts for

state and provincial legislatures to grant psychologists prescription privileges. However, psychologist prescription privileges is a highly controversial topic not only among psychiatrists, many of whom object to psychology's perceived infringement on their scope of service, but among psychologists themselves. Arguments from psychologists against prescription privileges include the threat that it poses to psychologists' professional identity by devaluing behavioral practice, concerns that psychologists will favor prescription of medication over implementation of behavioral strategies over time given its ease of application, concerns over patient safety, and increased malpractice insurance premiums (Hayes & Heiby, 1996; Lorion, 1996).

Government policy and economic forces have also impacted the provision of mental healthcare in Canada. The provision of medical services in Canada differs broadly from the United States in part because of Canada's publicly-funded healthcare system. At its inception, the Canadian public health insurance system only covered hospitalization for physical ailments, omitting coverage for mental illness (Romanow & Marchildon, 2003). Though coverage is now provided for treatment of mental illness, the services provided by psychologists are only covered in the public sector, not in private practice (CPA, n.d.a). In contrast, this insurance covers psychiatrists in both the public and private sector. However, many Canadians have supplemental health insurance through their workplace and these policies sometimes cover private psychological services. Hunsley et al. (2013) found that nearly half of patient services were paid for by a publically funded institution, and nearly a third were paid for directly by patients, of which 23% were reimbursed by private insurance and 11% were paid without any insurance reimbursement. Generally clinicians in the public sector are more likely to treat psychotic illness, while those in the private sector are more likely to provide assistance with life stressors, trauma, managing health, and vocational problems; anxiety disorders, depressive disorders, and interpersonal difficulties are commonly treated in both settings (Hunsley et al., 2013). Overall, mental health treatment in Canada is more likely to include medication than not (Romanow & Marchildon, 2003), leaving many Canadians who would benefit from psychotherapy without services. Canadian provincial psychological associations are actively advocating for an expanded role for psychologists in the Canadian healthcare system (CPA, n.d.b).

Summary

Clinical psychology has evolved and expanded from being solely an academic discipline, to including clinical work in the form of psychological assessment, to being dominated by psychotherapy. Throughout these changes, the commitment to research for the purpose of better understanding the human mind has continued. There are now two options for doctoral degrees: the more research oriented Ph.D. and the Psy.D., which is more practice focused but maintains an emphasis on the value of utilizing research. Training and clinical practice are increasingly focused on

integrating the research and practice elements of the discipline into patient care. However, current changes, such as the new PCSAS accreditation system, prescription privileges, and the RDoC project's greater emphasis on the contributions of genomics and neuroscience pose a potential risk to the continued integration of science and practice, and a risk to the continuation of behavioral science research and practice.

Licensure in psychology is regulated at the state and province/territory level. Every U.S. state requires a doctoral degree for the title of psychologist, whereas some Canadian provinces/territories allow for practice with a master's degree. Psychologists have a multitude of roles within and outside of the healthcare system including those of assessor, treatment provider, researcher, teacher, consultant, and administrator. Psychologists also work in a wide range of settings such as hospitals, clinics, private offices, schools, social service organizations, and academic departments. When working in clinical settings, psychologists are generally obligated to keep their communications with their patients confidential, though both legislation and action by courts have expanded the range of situations in which psychologists are mandated to break confidentiality. In New York, this includes situations in which an individual who may harm himself or someone else owns a firearm. There are a number of avenues for individuals to file ethics complaints against psychologists: some of the most common violations resulting in complaints and lawsuits are dual relationships, negligent or unprofessional practice, and improper record keeping.

The field of clinical psychology is highly influenced by broader healthcare policy and the practices of insurance companies. It remains uncertain how the Affordable Care Act (and its possible repeal and replacement) and other changes to the broader healthcare system will impact clinical practice and the role of psychologists in American life, though if the ACA functions as intended, it should increase access to behavioral health services and expand integrated medical and psychological care. It is also uncertain how the practice of clinical psychology will change in Canada, where the current health insurance system limits psychologists' roles.

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Central Europe

Ilse Kryspin-Exner, Oswald D. Kothgassner, and Anna Felnhofer

Introduction

It does not seem to be an arbitrary choice to revert to a Viennese scholar when trying to grasp the history and status quo of Clinical Psychology in Central Europe. Most people intuitively associate Sigmund Freud with Vienna, and thus, innately denominate one of the most influential founders of modern Psychology, who would not only be of great significance to Psychology and Psychotherapy in Central Europe but to Psychology and Psychotherapy all over the world. Also, the first author of this chapter held the first chair for Clinical Psychology in Vienna from 1998 to 2013 and thus, may be regarded a contributor to the establishment of academic Clinical Psychology in Austria and especially in Vienna. The two co-authors are, in turn, very familiar with the current educational system in Austria for Clinical Psychologists as they have, themselves, recently completed this training. The expertise from these two different positions hence, contributes to the holistic view approached in this chapter. In the following, these historical and recent developments shall be discussed in more detail and depth.

At first however, a chapter dealing with the status of Clinical Psychology in Central Europe is challenged to narrow down the term ‘Central Europe’. The conception of Central Europe as a region is influenced by historical, political as well as economical notions and thus, may considerably vary regarding its demarcations: for

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instance, one may argue that Central Europe may not only include Austria, Germany, Switzerland, but also Poland, Hungary, Slovenia, the Czech Republic, Slovakia and even the Baltic States as well as parts of Romania and Ukraine given that they all share some cultural and historical roots (c.f. Magocsi, 2002). However, as the current academic and legal status of Clinical Psychology differs significantly across the above mentioned countries, a chapter trying to equally account for all of these historically grown differences would quickly go beyond its scope. Hence, the present chapter will predominantly focus on the so called DACH-countries, Germany (D), Austria (A) and Switzerland (CH) where German is the first language for the majority of the population (c.f. Ammon, 2015). The advantages of such an approach are more in-depth insights into the particular developments and historical preconditions that led to what is now known as Clinical Psychology in large parts of Central Europe. Furthermore, it allows for a more differentiated analysis of current circumstances regarding Clinical Psychology's legal status, academic developments and practice. At present, these three seemingly close countries differ significantly with regards to their legal conception of Clinical Psychology and Psychotherapy. In Austria, for instance, the professions of Clinical Psychologists and Psychotherapists are regulated separately and thus, entail two entirely different, legally distinct professional guilds. In Germany and Switzerland, in turn, such overly strict dichotomy does not exist.

This being said, this chapter will briefly outline the history of Clinical Psychology, before moving on to a description of the status quo in Germany, Austria and Switzerland. The latter will not only include current views of Clinical Psychology in each of these three countries but will also consider differences in legal conceptions, education and training as well as research and practice. Above all, the contradictory legal and academic conceptions of Clinical Psychology and Psychotherapy (and, inevitably connected to this, the differing understanding of treatment vs. therapy or different interventions in general) will be discussed in detail for each country as they hold the key for many misunderstandings and—amongst others—vocational disparities between these countries (leading to, for instance, reduced mobility of professionals). Finally, possible changes of current practices shall be outlined and an outlook onto future developments of Central European Clinical Psychology in the twenty-first century shall be provided.

Historical Roots

To appreciate Clinical Psychology in its current form and to furthermore understand why its implementations and legal underpinnings differ in such an extent between the three neighboring countries Austria, Germany and Switzerland, one must revert to a brief analysis of its history. However, as is often the case with the portrayal of historical developments, an overview over the history of Clinical Psychology is subject to interpretation and judgement, and thus, shall never make the claim to be

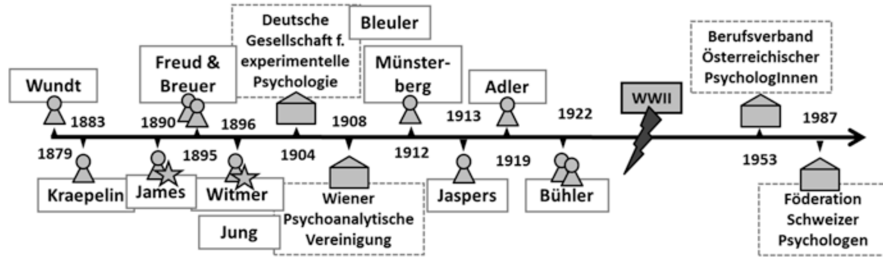

Fig. 1 Milestones of (Clinical) Psychology in Germany, Austria and Switzerland. Note: The *stars* in this figure designate the birth of Clinical Psychology as a discipline (marked by both the publication of James' *Principles of Psychology* and Witmer's establishment of the first psychological clinic). The two figures next to Bühler each indicate an important historical character (Karl and Charlotte Bühler). WWII: World War II (1939–1945). The institution's names are given in German, below they are spelled out in English as well

exhaustive and objective. It may be argued that the roots of today's Clinical Psychology reach as far back as to Roman and Greek philosophers and medics such as Hippocrates (460–370 BC) and may be traced throughout the Middle Ages and the Renaissance up until its—more or less—definitive emergence at the end of the nineteenth century (c.f. Petermann & Reinecker, 2005). However, for the purpose of this chapter, the authors will make an effort to concentrate mainly on the developments that took place in the three countries of interest. Figure 1 roughly depicts the historical milestones of Clinical Psychology in Germany, Austria and Switzerland. Apart from the most significant events, these countries' prominent historical figures are displayed and shall be discussed in more detail in the following.

In general, it is believed that Clinical Psychology as a sub-discipline of Psychology has a relatively short history, with an estimated beginning between the end of the nineteenth century and the beginning of the twentieth century (Petermann & Reinecker, 2005). Many view the year 1896 as the formal beginning of Clinical Psychology; it was around this time that American psychologist Lightner Witmer (1867–1956), a former student of Wilhelm Wundt, established the world's first psychological clinic at the University of Pennsylvania in Philadelphia and started to offer courses in clinical psychological methods (Reisman, 1991). Another trainee of Wundt, American psychologist and philosopher William James (1842–1910) may furthermore be regarded a key figure in the formation of Psychology as a scientific discipline: With his monumental book *Principles of Psychology* he laid the cornerstone for a natural scientific approach to Psychology.

The fact that the formation of Clinical Psychology as a discipline may be considered to first have taken place in the U.S. and not in a European country such as Germany or Austria necessitates a closer look at the parallel developments in Central Europe.

Developments in Germany

European Psychology, at this time, was closely related—if not at times identical—to medical concepts and in particular to Psychiatry and Neurology; most of its representatives originated from the medical sciences, and it was not until the German physician Wilhelm Wundt (1832–1920) called himself a psychologist that this designation started to be more frequently used among scholars. Wilhelm Wundt is commonly considered to be the father of modern scientific Psychology as he was the first to open a psychological laboratory at the University of Leipzig in Germany between 1875 and 1879. Also, Wundt introduced the idea of empirical verification of psychological theories and concepts and thus, laid a significant cornerstone for the birth of experimental Psychology (Reisman, 1991). Following this key event, various advances took place which little by little—and at times simultaneously—finally contributed to what we today consider to be the discipline of Clinical Psychology.

Around 1896, at approximately the same time as Witmer established the first psychological clinic in Philadelphia, another of Wundt's students, German psychiatrist Emil Kraepelin (1856–1926), published his notorious script *The Psychological Experiment in Psychiatry* ("Der psychologische Versuch in der Psychiatrie"), which would later constitute the foundation of modern classification systems. One of his most significant contributions was the illustration of how psychological methods such as the psychological experiment could be valuable tools for psychiatry (Kryspin-Exner, 2004b; Petermann & Reinecker, 2005). Soon after, in the spring of 1904, the *German Society for Experimental Psychology* ("Deutsche Gesellschaft für Experimentelle Psychologie") was founded in the context of the first congress for Experimental Psychology in Gießen, Germany, an event which additionally strengthened the position of Psychology in academia (Traxel, 1985). The society started with 85 members and would soon rise to approximately 200. However, in 1929 during the Viennese congress ("Wiener Kongress") it was rearranged and extended to include not only experimental Psychology but Psychology in general, and today it is well known as the *German Psychological Society* (Deutsche Gesellschaft für Psychologie, 2015).

Another student of Wundt and a rigorous advocate of Applied Psychology, the German psychologist Hugo Münsterberg (1863–1916) is also thought to have significantly contributed to the development of Clinical Psychology as a scientific discipline (Hergenhahn & Henley, 2013). Together with his colleague Wilhelm Specht he coined the term "Pathopsychologie" and edited the corresponding scientific journal "Zeitschrift für Pathopsychologie" (1912–1919) in which he defined mental illness as a deviation from normal mental processes; accordingly, psychological disorders, in his belief, could be explained with theoretical models of Psychology and treated with common psychological methods (Wirtz & Strohmer, 2013; see also Bastine, 1992). A position contrary to Münsterberg was taken by another German intellectual, the psychiatrist and existentialist philosopher Karl Jaspers (1883–1969), who in his book *General Psychopathology* ("Allgemeine Psychopathologie", Jaspers, 1965, 1973) perpetuated

the idea of symptoms as the smallest entities of a mental illness (Wirtz & Strohmer, 2013). Like his Swiss colleague Eugen Bleuler (see section "Developments in Switzerland"), Jaspers held a strong psychiatric position and may today be regarded as one of the pioneers of common classification systems for mental disorders (Kryspin-Exner, 2004b).

All of these examples illustrate how, around the turn of the century, first advances of German psychologists and psychiatrist to establish Clinical Psychology as an independent field of research and practice bore fruit. However, these developments may not be viewed as separated from progress in the realm of Psychotherapy but rather as concurrent and even reciprocal developments. Analogous to Austria, where Sigmund Freud with his method of psychoanalysis (for more details see section "Developments in Austria") lay the cornerstone for modern Psychotherapy, in Germany, too, a strong tradition of psychotherapeutic methods formed, some of its prominent figures being Ernst Kretschmer (1888–1964), Arthur Kronfeld (1886–1941) and Georg Groddeck (1866–1934), to name a few (c.f. Pritz, 2002). In other words, understanding the emergence of Clinical Psychology would be virtually impossible without, at the same time, considering the development of psychotherapeutic methods.

As flourishing as the advances in both Clinical Psychology and Psychotherapy were at the beginning of the twentieth century, World War I and II (WWI and II) abruptly interrupted these progresses. Academic advances in Psychology during WWII ceased almost completely in large parts of Europe as most scholars were of Jewish origin and were forced to emigrate during Nazi reign. In the U.S., however, Psychology was booming due to the need to develop assessments for military purposes and to treat veterans (c.f. Petermann & Reinecker, 2005; Pritz, 2002). After WWII, psychologists in Germany resumed their efforts and began to increasingly expand their expertise in psychological assessment, treatment and counseling. Again, this was—almost inseparably—related to and strongly influenced by developments in Psychotherapy, such as the formation of Client-Centered Therapy by American psychologist Carl Rogers (1902–1987) or the emergence of Behavioral Therapy in the 1940ies and 1950ies. Similarly, the work of German psychologist Hans Jürgen Eysenck (1916–1997) who was born in Berlin and later emigrated to London where he developed his well-recognized theories of intelligence and personality, had a great impact on Clinical Psychology in Europe.

In sum, the demand expressed by Emil Kraepelin (see above) to use psychological methods and theories to explain and treat mental disorders was finally met (Petermann & Reinecker, 2005). Furthermore, therapy methods such as Psychoanalytic Therapy (from 1967) and Behavioral Therapy (from 1980) could be officially applied by psychologists in Germany and were reimbursed by statutory health insurance as long as a medical doctor assumed responsibility (Petermann & Reinecker, 2005). However, the passing of a law regulating the self-employed practice of psychologists, who had an according postgraduate training took until 1998. It was by this time, that many professorships no longer bore Clinical Psychology in their title but also "Psychotherapy", a change that is still in effect today (see section "Status Quo of Clinical Psychology").

Developments in Austria

Austrian history regarding the development of Psychology and, in particular, of Clinical Psychology is evidently tied to the foundation of the initially called 'talking cure' and later termed Psychoanalysis by Sigmund Freud. To understand how this achievement could take place, one has to revert to the spirit in a late nineteenth century *fin-de-siècle* Vienna. It was during a time of social and political crisis and impending societal disintegration that the Viennese intelligentsia found fertile grounds for the development of their ideas (Schorske, 2012).

Among the leading pioneers of this era, if not the most important pioneer, was Sigmund Freud (1856–1939) who received his medical degree at the University of Vienna in 1881 and subsequently became more interested in Psychology than in neurology. He visited Jean-Martin Charcot (1825–1893) at the *Hôpital de la Salpêtrière* in Paris, France to learn how to apply hypnosis to patients with hysteria, and he kept in close contact with his colleague and father figure, neurologist Josef Breuer (1841–1925) (Reisman, 1991). In the early 1880ies Breuer treated a young woman suffering from hysteria who later became to be known as the infamous *Anna O.* By inducing catharsis, Breuer used a rather unconventional method at that time; Breuer discussed *Anna O.* with Freud multiple times and this would finally culminate in a mutual publication, *Studies in Hysteria* ("Studien über Hysterie") in 1895 (Reisman, 1991). Following this, however, the relationship cooled and Freud proceeded developing what would soon be known widely as Psychoanalysis. Many intellectuals followed him, one of the most prominent examples being Austrian medical doctor Alfred Adler (1870–1937) who would later break with classical psychoanalysis and form his own school of Psychotherapy, *Individual Psychology* ("Individualpsychologie"). Around 1908 the *Vienna Psychoanalytical Society* ("Wiener Psychoanalytische Vereinigung") an advancement of the *Wednesday Psychological Society* ("Psychologische Mittwoch-Gesellschaft") which assembled on Wednesdays in Freud's apartment was established. It included many prominent members such as—among others—Adler, Otto Rank (1884–1939) and Swiss psychiatrist and psychotherapist Carl Gustav Jung (1875–1961, for details see section "Developments in Switzerland"). This society was the first of its kind, but would soon be followed by many others all over the world; not to forget the significant influence of successors Anna Freud (1895–1982), Melanie Klein (1882–1960), Heinz Kohut (1913–1981) and Otto Kernberg (1928), who became famous for their work on personality disorders; for a review see "Austria: Home of the World's Psychotherapy" (Sulz & Hagspiel, 2015).

Other important figures which each significantly contributed to Viennese Psychology at the beginning of the twentieth century are German psychologist Karl Bühler (1879–1963) and his wife Charlotte Bühler (1893–1974). In 1922 Karl Bühler founded the first Department of Psychology at the University of Vienna, where he served as a professor of Psychology and Philosophy between 1922 and 1938 (c.f. Galliker, Klein, & Rykart, 2007). His wife, Charlotte, also became a professor in 1929 and vigorously supported the newly established Viennese Department

of Psychology. She dedicated her research to Developmental Psychology and to the study of systematic observation of behavior and the behavior of children in everyday situations, and in the 1920ies she opened the city's first *Child Adoption Center* ("Städtische Kinderübernahmestelle") (c.f. Bühring, 2007).

Another development taking place in Vienna in the 1920ies through to the 1930ies is worth noting at this point as it also bore far-reaching consequences for scientific Psychology: The so called "Wiener Kreis" (*Vienna Circle*). This circle included a group of scholars such as founder Moritz Schlick (1882–1936) and—at the periphery—Viennese philosophers Karl Popper (1902–1994) and Ludwig Wittgenstein (1889–1951) (c.f. Stadler, 2015). The Vienna Circle followed the self-proclaimed aim of promoting the philosophical position of Empirical Positivism which would become a central approach to contemporary statistical methods in modern Psychology.

Similar to Germany, in Austria WWII also inflicted a comparable halt of research and practice. Apart from the above mentioned, many other prominent psychologist and psychoanalyst such as Austrian neurologist and psychiatrist Viktor Frankl (1905–1997) who with his *Logotherapy* ("Logotherapie") may be regarded as the father of the "third Viennese school of Psychotherapy" emigrated. Frankl would later return to Vienna, after having taught at diverse U.S. universities, and would ultimately become known for his culture specific approach to Psychotherapy as well as for his notorious statement: "Jede Zeit hat ihre Neurose—und jede Zeit braucht ihre Psychotherapie" (Frankl, 2015 [1977])—*Every age has its own neurosis, and every age needs its own Psychotherapy.* Another Austrian psychologist who emigrated and followed his career in the U.S. was Frederick Kanfer (1925–2002). He made a quite significant contribution to today's cognitive behavioral therapy with the development of the self-management-therapy and with the so called SORC-model (a model of operant conditioning) (c.f. Sulz & Hagspiel, 2015).

Only few psychologists and psychotherapists remained in Austria to perpetuate Freud's heritage after the end of WWII (c.f. Pritz, 2002). In contrast to Germany, however, in post-war Austria, the development of Psychology and Psychotherapy did not go hand in hand and did not result in conjoint professorships and occupational profiles. By 1953 the first *Austrian Psychological Association* ("Berufsverband Österreichischer Psychologen") was brought into being as a reaction to the need of psychologists with an academic background to publicly distance themselves from other occupational groups that such as palm readers and fortune tellers (Berufsverband Österreichischer PsychologInnen, 2015a, 2015b). A corresponding psychotherapeutic association, the first *Austrian Psychotherapeutic Association* was not founded until 1981. At that time only medical doctors were officially allowed to apply Psychotherapy, however, most of those who actually practiced Psychotherapy did not originate from a medical background (Lenz, Rabenstein, & Görgen, 2011). The purpose, thus, of the association was to promote Psychotherapy and to legally strengthen this occupational group. It was, however, not until 1990 that an according law passed; this law regulated the occupational profile of psychologists and clinical psychologists on the one hand, and psychotherapists on the other and, hence, sealed their fate as two separate professional guilds. The consequences of

this historical division shall be discussed in more detail in the next section, when the status quo of Clinical Psychology in Austria is examined.

Developments in Switzerland

Psychology and Psychotherapy in Switzerland undoubtedly had their roots in psychoanalysis. One of Switzerland's most prominent figures in the history of Psychology and Psychotherapy, Swiss psychiatrist Eugen Bleuler (1857–1939) was closely linked to Freud's psychoanalysis, posing as one of the members of Freud's *Vienna Psychoanalytical Society* until he resigned in 1911. He was highly interested in the method of hypnosis, visiting himself—like Freud—Charcot in Paris and eventually became the director of the Burghölzli, the psychiatric hospital of the University of Zürich. Bleuler is most commonly known for his contribution to the conceptualization of schizophrenia which replaced the concept of dementia praecox, coined earlier by Kraepelin (Berrios, 2011). Also, he paved the way for the founding of the *Swiss Psychoanalytical Society* in 1919.

A student and assistant of Bleuler, Swiss psychiatrist Carl Gustav Jung (1875–1961) represents another important figure in the history of Swiss Psychology and Psychotherapy. He, too, was a follower of Freud's psychoanalytical theories and served as the president of the *International Psychoanalyst Association* between 1910 and 1914. However, the publication of *Psychology of the Unconscious* in 1912 ("Wandlungen und Symbole der Libido") led to a definitive divergence between Freud and Jung (c.f. Reisman, 1991). From this point on, Jung further developed his psychological concepts of the collective unconscious and archetype, leading to a separate branch of psychoanalytical methods which constitutes the main approach in Switzerland after classic Psychoanalysis (c.f. Pritz, 2002).

The overall development of Psychology and Psychotherapy in Switzerland was rather slow, generally lagging behind developments in other parts of the world (Pritz, 2002). After WWII, Swiss Psychotherapy was characterized by a pluralism of methods and approaches which all led to canton specific schools and associations, with the *Swiss Association of Psychotherapists* (established in 1979) being its largest representative. At the same time, Clinical Psychology professorships led to an arrival and thus, greater influence of behavioral therapeutic methods, and in the 1980ies the *Federation of Swiss Psychologists* ("Föderation Schweizer Psychologen"), the now largest association of psychologists in Switzerland, was founded (FSP 2015a, 2015b). Until recently, this association has promoted the right of psychologist to be the only other occupational group besides medical doctors to practice therapy in Switzerland and has managed to pass a law in 2013 that regulates the profession of psychologists and psychotherapists. Thus, similar to Germany and in stark contrast to Austria, Clinical Psychology in Switzerland may be viewed as closely linked to Psychotherapy. The current status of Swiss Clinical Psychology and its consequences for cross country mobility shall be discussed in more detail in the next section.

Status quo of Clinical Psychology

To define the status quo of Clinical Psychology, one has to first ask: What is Clinical Psychology? Concept such as counselling, Health Psychology, assessment and classification as well as prevention, treatment and rehabilitation of mental disorders seem to be at the core of Clinical Psychology. Following this notion, Clinical Psychology and Psychotherapy clearly cannot be regarded the same discipline or approach. According to Strotzka's (1969) definition, for instance, Psychotherapy may be seen as an essential part or subdomain of Clinical Psychology. Hence, in the following, their relationship shall be considered under this premise. Still, current statutory rules and educational programs only partly account for this definition. Especially in Austria there is a strict division between Clinical Psychology, Health Psychology and Psychotherapy. Furthermore, counselling and treatment are often used interchangeably in clinical psychological contexts and it is not considered that the objectives of counselling and treatment are inherently different (c.f. Kryspin-Exner, 2004a). Instead, the integrative, multimethodological and mostly evidence-based treatment approach of clinical psychological services would rather fit into existing therapeutic goals defining today's psychotherapeutic work than into counselling. This is, however, a notion that has yet to be realized in Austria. In contrast to Austria, German and Swiss regulations have already accommodated Strotzka's conceptualization of Psychotherapy: In both countries, predominantly medical doctors, psychologists and pedagogues who have successfully completed their—often quite time consuming—training may offer psychotherapeutic services to patients.

Germany

Education and Training. In Germany, two laws exist which allow admission to Psychotherapy: (1) the Psychotherapy law ("Psychotherapeutengesetz") and (2) the Healing Practitioner law ("Heilpraktikergesetz").

On the one hand, in Germany there is a profession called *Medical Psychotherapist* ("Ärztlicher Psychotherapeut"); generally, medical doctors (with an additional qualification in psychosomatic medicine, psychiatry and Psychotherapy or in child and adolescent psychiatry and Psychotherapy) who complete a 5-year training are admitted to this profession. However, they must have a proper additional qualification in Psychotherapy or Psychoanalysis or complete a corresponding psychotherapeutic training. In contrast to these medical psychotherapists, the so called *Psychological Psychotherapists* ("Psychologische Psychotherapeuten") need to graduate from 5-year academic studies in Psychology and are required to have an additional academic qualification in Clinical Psychology. *Child and Adolescent Psychotherapists* ("Kinder- und Jugendpsychotherapeuten"), in turn, may originate from the disciplines of medicine, Psychology and pedagogics alike. All of these three training options (medical psychotherapist, psychological psychotherapist and child and ado-

lescent psychotherapist) require the completion of academic studies and a state approved license. The according training incorporates not only theoretical studies but also a practical training (600 h) and 1800 h of hands-on training or work experience. In Germany, a psychological psychotherapist may specialize in psychoanalysis, depth Psychology, behavioral therapy, person-centered Psychotherapy (or talk-Psychotherapy) and systemic Psychotherapy, however reimbursements for patients are only given for a selection of specific therapeutic schools (see below).

On the other hand, psychotherapeutic interventions may be offered to patients in the realms of the *Healing Practitioner Law* ("Heilpraktikergesetz"). This occupational group, however, is not allowed to use the occupational title "Psychotherapist". Instead, this group is not bound by any specific treatment method and may acquire the title of an accredited Healing Practitioner by passing the Healing Practitioner exam. In Germany, these exams may be taken in private associations.

Today, there is a lively debate in Germany about providing an academic Psychotherapy graduation instead a post-graduate training for people who completed an academic education in medicine, Psychology or pedagogics ("Direktausbildung"). A number of corresponding models and conceptualizations for the realization of this endeavor have already been published and are being discussed quite lively at this point (e.g. Fydrich et al. 2013; Rief, Fydrich, Magraf, & Schulte, 2012).

Practice. In Germany, with a population of around 81 million, there are around 13,400 Psychological Psychotherapists, 3,100 Child and Adolescent Psychotherapists and 5,300 Medical Psychotherapists who are mostly employed in outpatient settings or private practices. Additionally, there are Psychiatrists and Pediatricians in private practice as well as around 7,000 Psychotherapists in inpatient clinics (Bundespsychotherapeutenkammer, 2015). However, a reimbursement for patients via statutory primary health care is only possible for the group of psychotherapists who are specialized in one of three accredited psychotherapeutic schools: depth Psychology, psychoanalysis or behavioral therapy (according to the so called guideline policy, "Richtlinienverfahren") (Gemeinsamer Bundesausschuss, 2014).

Austria

Education and Training. In Austria, clinical psychologists are subject to two federal laws: (1) the so called *Law for Clinical Psychologists and Health Psychologists* ("Psychologengesetz für Klinische Psychologen und Gesundheitspsychologen") and the (2) *Psychotherapy Law* ("Psychotherapiegesetz"). On July 1st 2014, a new law for clinical psychologists and health psychologists was passed. The amendment to the Psychotherapy law is still pending, but is expected for the next couple of years. The current Austrian law strictly separates the postgraduate training for clinical psychologists from the one for psychotherapists.

Clinical psychologists are required to graduate from a 5-year academic training in Psychology (without the additional requirement of specializing in Clinical Psychology, as it is in effect in Germany). Additionally, they have to successfully

complete a 2 year post graduate training, comprising both a theoretical education and (in most cases financially not well compensated) hands-on practice. Altogether, 2,188 h of practice have to be completed in a health care institution (e.g. an inpatient clinic). In addition to the title of a clinical psychologist, there is a parallel training for health psychologists which may be completed together with the training for clinical psychologists as it has comparable requirements. In Austria, health psychologists are allowed to provide services within the realms of prevention, health promotion and rehabilitation. In contrast, clinical psychologists are also allowed to diagnose patients according to ICD guidelines. Both trainings may be completed via a number of specialized non-governmental education facilities.

Psychotherapists, in turn, may originate from diverse occupational backgrounds, usually referred to as "Quellenberufe" (so called source professions). This category subsumes medical and social professions such as medical doctors, psychologists, pedagogues but also social workers, teachers, nurses etc. However, persons not belonging to this class of "Quellenberufe" may also acquire the permission to initiate Psychotherapy training and consequently, practice Psychotherapy. For this, they have to file a petition to the *Austrian Federal Ministry of Health* ("Bundesministerium für Gesundheit"). In general, psychotherapists are not required to complete academic studies, yet the number of Applied Universities and post-graduate Centers which offer courses within the scope of psychotherapeutic sciences is on the rise in Austria and thus, a trend towards providing a forthright education like in Germany may be observed ("Direktausbildung").

Today, most federally accredited educational institutions providing curricula for psychotherapists remain in the hands of private associations. To achieve the title of a psychotherapist, the trainees—after having completed a basic training ("Propädeutikum")—have to choose one of the 23 currently licensed psychotherapeutic disciplines or schools of thought (see Table 1).

The training comprises (extra-occupational) theoretical courses as well as hands-on experience which, much like in the case of clinical psychologists, is only poorly compensated. The overall time for training is around 6–8 years, however, psychotherapists are allowed to practice from quite an early stage on, provided that they are closely supervised. Upon completion of the training, both clinical and health psychologists as well as psychotherapists are registered at the *Austrian Federal Ministry of Health* ("Bundesministerium für Gesundheit"; the according list may be accessed online: http://klinischepsychologie.ehealth.gv.at/). Furthermore, additional qualifications such as the licensed industrial psychologist ("Arbeits- und Organisationspsychologe") or the licensed child and adolescence psychologist may be acquired via diverse professional institutions.

Practice. In Austria, with a population of approximately 8 million, 7,871 psychotherapists and 8,692 clinical psychologists were registered in 2014. Around 98% of clinical psychologists held the additional title of a health psychologist. Also, double qualifications in Clinical Psychology and Psychotherapy make up around 25% of all practitioners. The majority of psychotherapists are female, and around 61% work in private practices. In Austria, there is a shortage of psychologists and psychotherapists in rural areas, most psychologists have settled in cities; in fact, the majority of clinical psychologists work either in Vienna or Salzburg (GÖG/ÖBIG, 2014).

Table 1 23 Psychotherapy disciplines/schools of thought in Austria (BMG, 2015)

Cluster I: Depth Psychology and Psychoanalysis	
Psychoanalytical methods	*Depth Psychology*
Analytical Psychology	Autogenic Psychotherapy
Group analytic Psychotherapy	Daseinsanalysis
Individual Psychology	Dynamic group therapy
Psychoanalysis	Hypnotherapy
Psychoanalysis-oriented Psychotherapy	Guided affective imagery
	Concentrative movement therapy
	Transactional-analytic Psychotherapy
Cluster II: Humanistic orientation	*Cluster III: Systemic orientation*
Existence analysis	Systemic family Psychotherapy
Existence analysis and logotherapy	Neurolinguistic programming
Gestalt theoretical Psychotherapy	
Integrative gestalt Psychotherapy	*Cluster IV: Behavioral therapy*
Integrative therapy	Behavioral therapy
Psychodrama	
Person-centered Psychotherapy	
Person-centered approach Psychotherapy	

The main task of clinical psychologists in the Austrian health care system is conducting psychological assessment which is fully reimbursed via the statutory primary health care. Usually, a referral from a medical doctor is required in order to be eligible for reimbursement. However, short-term and long-term clinical psychological treatment—which, in contrast to Psychotherapy, may be understood as a multimethodological approach based on theories and models of Psychology and evidence-based methods focusing in the first line on maladaptive psychological functions of biopsychological and neuropsychological processes (cognition, emotion, learning processes and experience)—is not reimbursed via statutory primary health care at this point in time. Yet, in the context of their intervention (be it counselling or treatment) clinical and health psychologists may autonomously apply therapeutic interventions which need to be financed privately by the patient or, alternatively, via complementary insurance (Berufsverband Österreichischer PsychologInnen 2015a, 2015b).

For psychotherapists the situation is slightly different: Here, too, a referral from a medical doctor is required. However, part of the psychotherapeutic treatment—and in some cases the whole treatment—is reimbursed by statutory primary health care. In contrast to clinical psychologists, psychotherapists are bound to their school of thought and have to clearly designate their additional qualification (e.g. Person-centered Psychotherapy or Behavioral Therapy etc., see above).

Switzerland

Education and Training. On April 1st 2015 the *Federal Law about the Psychological Profession* ("Bundesgesetz über die Psychologieberufe, PsyG"; for the legislative text—in German—see Bundesversammlung der Schweizerischen Eidgenossenschaft, 2013) not only officially established proprietary titles for psychologists but also regulated education, training and occupation of psychotherapists in Switzerland (Law News, 2013). Previously, practicing Psychotherapy and Psychology had been a matter of each Swiss canton and thus, often resulted in quite differing approaches (c.f. Pritz, 2002). The new law now accomplished a country wide harmonization and synchronization of criteria for education, training and practice (FSP, 2013a). Hence, only those who have a master degree (or a comparable degree) in Psychology may bear the title of a psychologist. To offer psychotherapeutic services, one has to additionally complete an according postgraduate training in Psychotherapy (Law News, 2013).

In general, a distinction is made between two professional groups, psychologists and psychotherapists, which each have different training backgrounds and areas of practice (FSP, 2013a):

1. *Psychologists*: have a master degree or diploma in Psychology and are allowed to conduct counseling but not Psychotherapy.
2. *Psychotherapists*: a distinction is made between psychologists who receive additional training in Psychotherapy who are then allowed to call themselves *Specialist Psychologist for Psychotherapy FSP* ("FachpsychologIn für Psychotherapie FSP") or *Psychological Psychotherapists* ("Psychologische Psychotherapeuten") and medical doctors with a degree in psychiatry who go through the according psychotherapeutic training (*Medical Psychotherapists*, "Medizinische Psychotherapeuten").

Additionally, the *Federation of Swiss Psychologists* ("Föderation der Schweizer Psychologinnen und Psychologen, FSP") has introduced so called specialist titles which are designated with the ending FSP, one of which is the title *Specialist Psychologist for Clinical Psychology FSP* ("Fachpsychologe/Fachpsychologin für Klinische Psychologie FSP") (FSP 2015a, 2015b). It requires an additional postgraduate training for psychologists which may be completed via the *Swiss Association of Clinical Psychologists* (der Schweizerischen Vereinigung Klinischer Psychologinnen und Psychologen SVKP) and which incorporates further training in Psychotherapy (SVKP, 2015). However, the accreditation is still pending (c.f. FSP 2015a, 2015b).

Practice. According to recent data (FSP, 2013b), 5,700 Psychological Psychotherapists currently work in Switzerland (with a population comparable to Austria of approximately 8 million), most of them part-time. Most prominent are four areas of occupation: (1) self-employed in a psychotherapeutic practice, (2) delegated in a psychotherapeutic practice, (3) in an outpatient clinic and (4) an inpatient clinic (FSP, 2013a). For the first occupational group, a reimbursement via

statutory primary health care is not possible at this time, patients have to pay for this kind of Psychotherapy privately or they are reimbursed via complementary insurance. So called delegated psychological psychotherapists are employed at a medical practice; their services are supervised by a medical doctor and may be reimbursed via the statutory health care system. The psychological psychotherapists wage is subject to negotiations with the employing medical doctor. There has been extensive debate and attempts to change this situation which initially posed as an interim solution until the occupation of psychotherapists would be regulated by law (FSP, 2013a). Even though the corresponding law has passed, a tangible model for implementation is still to be drawn.

General Considerations and Outlook

Today, the continuous and rapid growth in the number of mental disorders in Europe undoubtedly poses one of the greatest challenges for the health care system. One year prevalences between the years 2005 and 2010 demonstrate large increases in overall psychological disorders from 27 to 38% (Wittchen et al., 2011).

Towards a Clinical Psychology in the Digital age

In light of the mostly poor provision of clinical psychological or psychotherapeutic services in rural areas (in all three countries of interest) new approaches to treatment and intervention need to be considered. Here, especially eMental Health Programs (c.f. Rochlen, Zack, & Speyer, 2004) as well as online therapy and training come into play (Lehenbauer, Kothgassner, Kryspin-Exner, & Stetina, 2013). They may be used to reach out to people who live in an area with a low density of supply of psychotherapists or clinical psychologists or persons who are immobile or bed-ridden. However, the peculiarity of technological applications such as the Internet is that on the one hand new problems may surface and that on the other hand known mental disorders may take on a new shape (c.f. Kryspin-Exner, Felnhofer, & Kothgassner, 2011). For instance, behavior based addictions in combination with the use of the Internet have been on the rise and have been reported to be highly comorbid with other psychological disorders (Kuss, Griffiths, & Binder, 2013). Similarly, bullying and ostracizing others via digital media is a considerably novel phenomenon (Petermann & von Marées, 2015). The fairly open culture and seemingly borderless reach of virtual space renders many persons, especially children and adolescents, quite vulnerable, especially considering that the emotional reaction to cyberbullying or virtual exclusion is comparable to face-to-face bullying and social exclusion (Kothgassner et al., 2014).

Clinical Psychology and the Challenge of Demographic Change

Furthermore, the current and predicted demographic change poses a great challenge for Europe not only with regards to the increase in numbers of socially isolated and depressed persons but also with respect to the rise in chronic and degenerative diseases such as Alzheimer's disease (Weyerer & Schäufele, 2004). Diverse EU programs and national funds try to live up to these developments. For instance, technology aided interventions and surroundings (i.e. Smart Homes) shall help the elderly participate in society (e-inclusion) as well as be more active via social networks in order to prevent isolation and depression (Active Ageing, c.f. Felnhofer et al., 2014). Similarly, fall detection and fall prevention systems, nursing robots as well as the use of automatic aids or even the application of deep brain stimulation in the case of Parkinson patients is promoted to help facilitate coping with every-day life (Hartanto et al., 2015; Kaiser, Oppenauer-Meerskraut, Kryspin-Exner, Czech, & Alesch, 2010; Planinc & Kampel, 2013; Suryadevara & Mukhopadhyay, 2014).

Pathways from Clinical Psychology to Clinical Neuroscience

Apart from developments in technology-based treatment, many research groups in Central Europe focus on a neuroscience approach including mainly structural and functional brain imaging methods. The main objectives of this approach are, on the one hand, to understand mental processes and their biological associations and, on the other hand, to use these methods for the assessment of mental diseases. At this time, however, this approach does not seem to significantly enhance diagnostic reliability, let alone, to be used as a stand-alone assessment of psychological disorders. Neuroimaging and electrophysiological methods may provide diagnostic markers associated with mental disorders, but lack the sensitivity and specificity to be qualified as a useful tool to predict criteria for psychiatric disorders or to help distinguish specific mental disorders from other diseases (ADHD-200 Consortium, 2012; Linden, 2012). Concerning the substantial costs as well as the problems of usability with a wide range of psychiatric patients (e.g. problems with head motion), neuroscience methods are in critical need for both significant improvement and more research (van Dijk, Sabuncu, & Buckner, 2012).

Another point of entry for neuroscience into Clinical Psychology is the gradually increasing use of neurofeedback, i.e. for the treatment of ADHD or antisocial personality disorder (Arns, Heinrich, & Strehl, 2014; Konicar et al., 2015). In light of these biological trends in Clinical Psychology, it is important to remember the social context and developmental aspects rather than focusing only on not yet empirically proved neurobiological procedures. They are a scientific challenge but should be better integrated into existing health care settings as they are less cost intensive and thus, may be regarded as low-threshold (c.f. Pickersgill, 2011).

Issues of Clinical Psychology in Society and Practice

Studies suggest that only 10% of those in need of clinical psychological or psychotherapeutic services actually receive treatment (Wittchen & Jacobi, 2001). On the one hand, this puts more emphasis on the role of Psychology as a profession (i.e. by actively involving Central European psychologists in the development of criteria for a rather medically oriented ICD-11); on the other hand, however, there are still considerable societal resentments towards individuals with mental disorders, although more than a third of the population suffers from a psychological disorder during the course of their lives. This attitude feeds social stigma which in turn both hinders the timely call for help in those concerned and may promote a chronification of mental disorders. The absence of low-threshold services especially in rural areas (as well as affordable interventions) may be in part responsible for those low rates of treated patients in Central Europe.

Hence, the efficient application of technology based approaches as well as further development of psychological and psychotherapeutic services should be pursued with more rigor. Especially regarding the transition from adolescence to adulthood or from an in-patient clinic to out-patient treatment, substantial gaps in coverage are observed, mostly due to regional differences in health-care services provision. Improving these transitions is considered to be one of the greatest goals for the near future. However, there are many barriers to transition such as a lack of insight into mental health problems or the social stigma associated with mental health problems for young people. Empirically-based studies, especially RCT (randomized control trials) studies are needed to improve standardized and accurate services for young adults (Paul, Street, Wheeler, & Singh, 2015; Paul et al., 2013).

Today, Clinical Psychology in Central Europe is—not least because of the current increase in refugees seeking shelter in Europe—in dire need of including transcultural approaches. Culture sensitive psychological treatment and assessment constitute essential means in order to avoid misdiagnosis which may not only prolong treatment but also critically decrease acceptance of psychotherapeutic and clinical psychological interventions (Lago, 2011).

Another issue is the challenge regarding the development of Clinical Psychology and Psychotherapy education in future. The differing educational standards and diverse occupational titles for similar or even the same services undoubtedly pose as the greatest stumbling blocks for pragmatic low-threshold solutions. Fundamental restructuring may be regarded a chance for improved patient-centered provision of psychological and psychotherapeutic services (in Germany, for instance, it is common for a university to house patient clinics for research and teaching purposes).

Summary

From a historical perspective, the developments of Clinical Psychology in Central Europe paint a heterogeneous picture. Apart from the establishment of an empirical Psychology via Wundt and his successors, a strong tradition of Psychoanalysis and

In Depth-Psychology schools took hold of the three DACH-countries. The large variety of Psychotherapy schools has not only critically influenced the formation of Clinical Psychology but has also contributed to the now quite multifaceted and conflict prone landscape of Clinical Psychology in Central Europe: Austria, Germany and Switzerland—three countries sharing common cultural roots—are characterized by differing (at times contradictory) legal situations regarding the education, training and vocational standards for Clinical Psychologist. This leads to both a reduced cross-country mobility of professionals and difficulties in mutual exchange on all levels.

Today, Clinical Psychology in Central Europe also faces another challenge which may be critical for its future place in health care: Technological developments provide Psychologists with a wide range of possibilities for application in both assessment and treatment situations. However, the potential of many technologies is still not being used or is being used inconsiderately. Another challenge consists of providing psychological or psychotherapeutic services to all of those in need: For instance, institutional structures are needed for minors with mental disorders who are in the process of transitioning from adolescence to adulthood. Similarly, there is an increasing necessity to attend to traumatized refugees with different cultural backgrounds. This highlights the importance of culture sensitive Psychotherapy and Clinical Psychology.

In sum, there is a need to fundamentally restructure patient-centered provision of psychological and psychotherapeutic services in Central Europe. But whether the so called *Bologna Process* (an agreement to ensure comparability in academic education across European countries) and the subsequently initiated direct education of psychotherapists in Germany and also possibly in Austria will fit the requirements for change remains to be seen. The difficulty of harmonizing these structures even in countries of similar cultural and language background (i.e. the DACH-countries), reflects the upcoming challenges for the European Union and the European health care system.

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Eastern Europe

Daniel David and Simona Stefan

Introduction

Clinical psychology, defined as the field in psychology "integrating science, theory and practice to understand, predict, and alleviate maladjustment, disability, and discomfort, as well as to promote human adaptation, adjustment, and personal development" (Division of Clinical Psychology, [Division 12] of the American Association of Psychologists [APA], 2010]) has been an important preoccupation for psychologists in Eastern Europe but the profession of clinical psychologist is a relatively new endeavor. What clinical psychologists do, how they are trained, how the profession is formally licensed, what people think of it, and how it came to develop to the point it is today varies among Eastern European countries, and it is beyond the scope of this chapter to describe each case in detail. Still, despite these differences, the image of clinical psychology appears in many ways different from the western world. Inspired in the beginning both by the Pavlovian experimental tradition in the USSR and by the German experimental work starting from Wilhelm Wundt, Eastern European psychology (as all mental health professions) was eventually largely influenced by communist ideology, and now faces somewhat similar challenges related to unclear profession boundaries and licensing standards, operating in societies with generally fewer resources (i.e., as compared to Western Europe and the United States), where people and the medical system still associate mental health mostly with psychiatry. Therefore, in this chapter, we will try to outline (1) a brief history on clinical psychology in Eastern Europe, (2) work settings in clinical psychology, and (3) the current training system and licensing.

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A Short History

The beginnings of scientific psychology in Eastern Europe can be traced back to the end of the nineteenth century—beginning of the twentieth century, when former disciples and collaborators of Wilhelm Wundt introduced experimental psychology and founded the first laboratories, like in Romania (David, Moore, & Domuta, 2002; Iliescu, Ispas, & Ilie, 2007), Hungary (Laszlo & Pleh, 1992), or Bulgaria. Poland also began the study of psychology in an experimental tradition, with the first laboratory of experimental psychology founded by Władysław Heinrich in 1903, with two more laboratories following shortly (in 1907 and 1915) (Brzezinski & Strelau, 2005). Therefore, in many Eastern European countries, psychology started in a scientific, experimental background, psychologists here contributing to the international literature and maintaining close ties to the West. In the clinical field (although clinical psychology was not established as a field at international level either), some countries in Eastern Europe began a strong psychoanalytic tradition (including imperial Russia), in some cases continuing to this day (e.g., Hungary; Laszlo & Pleh, 1992).

In Russia, before the communist revolution, inspired by the works of the famous physiologists Sechenov and Pavlov and by the experimental tradition already starting in the West, Russian psychologists (e.g., Bekhterev) initiated laboratories and research institutes rivaling those in western countries, in terms of available technology and knowledge (Grigorenko, Ruzgis, & Sternberg, 1997). However, after the communist revolution, Russian psychology followed a different path. Starting the 1920s, soviet psychologists (Vygotsky, Luria and Leont'ev being the most prominent scholars) enthusiastically outlined new research directions, inspired by the soviet philosophy of creating "the new man"; adopting some ideas from western psychologists, they also criticized their approach and envisioned a new psychology, both materialistic (experimental) and complex, considering cultural variations to a wider extent compared to western psychology (Hyman, 2012). In a seminal book, called *the Historical Meaning of the Crisis in Psychology* (1927; Janoušek & Sirotkina, 2003), the famous psychologist Lev Vygostky criticized the fragmentation in the field and the lack of communication between the different schools of thought (i.e., psychoanalysis, reflexology and behaviorism, Gestalt, personalism), stating that psychology gets further and further away from a unifying perspective, thus struggling with an important crisis. In his view, the Soviet psychology school (i.e., cultural-historical psychology) would be a viable alternative by offering a general, unifying perspective on mental life, guided by the principles of Marxist philosophy.

Prominent soviet psychologists, like Vygostky and Luria were erudite in their knowledge of psychological literature (including western literature), they were in contact with western researchers, and they left valuable works, known today in western psychology as well (e.g., Vygostky's concept of proximal development zone). Unfortunately, cultural-historical psychology did not succeed in becoming the unifying force it had been envisioned, for various reasons.

For instance, although Vygostky stated that this new psychology should be developed in deep connection with practice, this did not happen, as theory and practice grew further apart starting the 1930s, when political control became much more repressive in the USSR. Also, Soviet psychology did not consistently try to synthetize/unify previous psychological knowledge from the other schools, but formulated its own principles and remained relatively isolated from western psychology (Mironenko, 2013). In this sense, Vygostky himself had been accused of "bourgeois leanings" for citing western authors (Grigorenko et al., 1997), which would surely discourage scientific interest in western works, and later, in the 1950s, Pavlov's approach was officially proclaimed as the only scientific approach in psychology (Avtonomova, 1996). After the 1950s, however, psychologists previously accused of sympathizing with the West were rehabilitated and the political control over psychological science diminished.

Traditionally, since the 1930s, the Russian school followed a theory-driven style of work, proposing elaborate concepts and classifications, and relying much less on experimental work. However, this may also be a reasonable consequence of the consistent lack of funding for psychological research (Ritsher, 1997). Following the years after the Second World War, the Russian school of thought in psychology was gradually largely enforced (and embraced) in the other east-bloc countries as well. One notable exception seems to be Poland, where, following a rather short period of repression in the 1950s, psychology developed relatively free from communist ideology, remained an established profession, and, in the field of psychotherapy, more treatment modalities were embraced (Aleksandrowicz, 2009).

During the communist period (Second World War—1989/1990), in Eastern Europe, many ideas of western psychology were discredited since focusing on the individual's mental processes and not concentrating on social forces was considered dangerous in societies formed on new collectivist principles (Winstead, 1984). Psychologists in the east started following the Russian model, in terms of philosophical roots and research topics and practice. Therefore, psychology was mostly theory-driven, and experimental endeavors focused mostly on work psychology and educational psychology (e.g., dealing with children with cognitive or sensory disabilities). Clinical psychology and psychotherapy were clearly underrepresented since there were virtually no teaching and licensing programs, communist societies considering they were not needed, as psychiatrists were the only ones dealing with mental health issues. For instance, the soviets claimed that common mental health problems (e.g., depression, anxiety) had been caused by social inequities, and that, once these were eliminated by an equalitarian and prosperous society (like the USSR supposedly was), such mental health issues should no longer occur. Other psychiatric disorders, more severe ones, like schizophrenia, were believed to have biological causes, and were therefore treated by psychiatrists according to a biomedical model (Yakushko, 2005). In this context, psychologists working in mental health settings usually acted as psychiatric assistants, doing mostly testing. Also, this broader vision, that severe psychiatric disorders need medical psychiatric treatment while "neurotic disorders" need only guidance and council (i.e., delivered for instance, by family doctors, in primary care) is still largely spread in Eastern Europe

(Milosz, Winstead, 1984), contributing to the stigma associated with seeking psychiatric/psychological help.

With reference to mental health systems, it is worth mentioning that in the USSR, and not so much in other communist countries, until the 1980s, psychiatric diagnoses and treatment methods were often used to deal with political dissidents. In this sense, president Khrushchev explicitly stated in a speech in 1959 that anticommunist dissidence was inherently a product of mental illness (Tomov, van Voren, Keukens, & Puras, 2007). In those days, such individuals could have been easily diagnosed with what was called "sluggish schizophrenia", a diagnosis category introduced by Professor Snezhnevsky, the Director of Psychiatry at the Soviet Academy of Medical Sciences (Targum, Chaban, & Mykhnyak, 2013). In his view, this category was characterized by a "negative axis", including conflict with authorities, poor social adaptation, and pessimism, with no compulsory presentation of psychotic features (Targum et al., 2013). Thus, it can be easily seen how political dissidents could easily fit this diagnosis pattern. Following this diagnosis, suspected political dissidents were sent to special hospitals (maximum security forensic hospitals) and/or regular psychiatric hospitals, and were often subjected to physical, pharmacological, and psychological abuse before being released back into society (Ougrin, Gluzman, & Dratcu, 2006; Petrea & Haggenburg, 2014). Even after being discharged, former patients (either mentally ill or hospitalized on political grounds) could not pursue a normal life since a diagnosis of schizophrenia excluded them from almost all skilled and professional work (Petrea & Haggenburg, 2014). In this sense, it is estimated that about a third of political prisoners in the USSR were institutionalized in psychiatric hospitals (van Voren, 2010). Unfortunately, except the works written by soviet psychiatrists, the sources of information were very limited, and eastern psychiatrists had a rather thin knowledge of western progresses (Targum et al., 2013). Even so, it is not that this policy of treating political dissidents as mentally ill has remained unchallenged, since few, if any Russian psychiatrists actually believed this was the case. The reason why this approach became established lies with the fact that psychiatrists who opposed it frequently lost their jobs and some were even deported to Siberia (Tomov et al., 2007). Surely, this approach to mental health has changed rapidly after the change in the political regime.

Typical for Eastern European countries is the approach of mental health problems almost exclusively in secondary care (i.e., not in primary care, and not in community centers), most countries now in a long process of transition towards a primary and community-based care model (e.g., Bosnia and Herzegovina; Sinanovic et al., 2009; the Republic of Moldova; Zinkler, Boderscova, & Chihai, 2009). Partly, this seems to be a consequence of the long-term stigmatization of mental illness by politics, the media, and even by mental health professionals and the general public. Stigma associated with mental illness is a problem everywhere; however, in former communist countries even more so, since the main purpose of healthcare for disabled individuals (both mentally and physically) was for a long time the protection of "regular" individuals. Therefore, care was not so much focused on integrating suffering individuals in society, but they were rather institutionalized and isolated from the rest (Tomov et al., 2007). This approach was rather common in the eastern

bloc, and its legacy remains to this day. Even now, among the countries of the European Union, former communist countries (especially Romania and Bulgaria) have lower indexes of social integration for people with serious mental illness. However, interestingly, the index is low also in countries which were not part of the communist bloc (Greece, Portugal) (Mental Health and Integration; A report from the Economist Intelligence Unit, 2014).

Concerning costs, mental health care has been and still is free for most people, based on national insurance systems, whereas clinical psychology and psychotherapy services are usually not covered, because, typically, they are not considered part of the medical field. This comes as a consequence of the fact that the health field has been considered to be almost exclusively related to medicine (thus *healthcare* and *medical care* are synonymous in Eastern Europe), and very little to psychology. However, in this respect, eastern European countries are highly heterogeneous, depending on their own scientific tradition, and also on their diverse economic and political situations.

In some instances, apart from being rephrased in terms of ideological purposes, psychology was even forbidden from being studied in universities, although this was not the case in most communist countries. For example, in Romania, psychology as an independent scientific academic discipline was forbidden starting 1977 since the communists considered it was their task (and competence) to help form "the new man", thus leaving no "role" for psychologists. Later, in 1982, a group of psychologists and physicians invited western colleagues to organize training programs on transcendental meditation, a practice considered subversive by the communist regime (David et al., 2002). Then, by an order of the communist president Ceausescu, psychology was also forbidden as a scientific field. As an aftermath, some of the psychologists involved in this movement were imprisoned or forced to work in factories, while those who were not part of it were transferred to other departments, like Educational Sciences and Philosophy (David et al., 2002). Another example is Poland, where the psychology profession was eliminated and psychological testing forbidden between 1950 and 1956, in practice psychologists performing the attribution of psychiatric assistants, something similar to a lab technician or social worker (Cierpiałkowska & Sęk, 2016). After these years of crisis (politically, corresponding to the affirmation of Polish independence in reference to the USSR), however, psychology in Poland reasserted itself as a scientific discipline and valuable practice that was applied to the clinical field as well. Clinical psychology conferences were organized starting the 1950s, and, after the 1960s, departments and units of clinical psychology were organized in universities (see Cierpiałkowska & Sęk, 2016).

Work Settings in Clinical Psychology

After the fall of the Iron Curtain in 1989/1990, a challenging time of transition towards democratic values began for the former communist countries in Eastern Europe, and to some extent continuing to this day, with large differences among

countries. This transition has been particularly difficult because the acute societal needs for modernization met with increasing economic difficulties in most sectors, health, and particularly mental health, included.

As previously mentioned, during communist times, mental health care was addressed almost exclusively in secondary, specialized care, either in hospitals or ambulatory units (policlinics, dispensaries), while neurodevelopmental issues (e.g., mental disability) were also addressed in special education institutions. The stigma associated with mental illness was high, as communist societies emphasized, albeit with some differences between countries, that individuals not well adapted in society due to disability were neither needed nor wanted. Milder emotional problems, like depression and anxiety, were not usually reported to mental health care professionals, and were considered part of normal suffering in life, which, in many Eastern cultures, needs to be kept private (Winstead, 1984). This view persists to this day in Eastern Europe, although things have started to change for a while, especially in urbanized, more economically-developed regions. Interestingly, the stigma remains high even among those who do seek psychological help. For instance, it is not uncommon for people to anxiously ask their psychologist whether they are "truly" mentally ill, considering that psychiatric conditions are inherently a form of madness, associated with continuous decay and a complete loss of control.

With reference to the accessibility of treatment for mental health issues, the situation in Eastern Europe is worse than in the west, most patients in need not receiving adequate treatments. For example, prevalence of depression and suicide rates have increased dramatically in the 1990s and alcohol related diseases are more prevalent than in the West (e.g., Russia, Ukraine, Romania, etc., Jenkins et al., 2015; Petrea, 2012). For instance, in Russia, as a consequence of instability and the high rates of alcohol dependency, suicide rates have increased, along with the number of socially disadvantaged families and social orphans (Kholmogorova, Garanian, & Krasnov, 2013). Currently, many countries in Eastern Europe are implementing reforms in the mental health-care system, with a focus on establishing primary-care services to take over "milder" psychological disorders, so far addressed in the overcrowded secondary care system (e.g., the Russian Federation, former Yugoslavian countries, the Republic of Moldova, the Ukraine, etc.). As this appears as a more constant direction followed through consistent health policy reforms, the inclusion of clinical psychology services in the field of mental health varies widely from one country to another, remaining, to our knowledge, somewhat ambiguous in most cases.

Most clinical psychologists in Eastern European countries work in hospitals, counselling patients with somatic medical conditions, psychiatric hospitals, assisting psychiatrists in diagnosis and treatment management (e.g., psychological testing), child protection services (e.g., assessment and intervention with abused children, assessment of parents and foster parents) or forensic settings (e.g., assessment and intervention with incarcerated individuals, psychological assessments required by court). Clinical psychologists are also expected to conduct compulsory psychological evaluations required for certain professions (e.g., military, teachers, policemen) or when psychological evaluation are needed for reaching administra-

tive decisions (e.g., early retirement). At this point, it is worth mentioning that, after 1989/1990, psychology became a much more popular career choice for youngsters, and many universities started psychology programs. For example, in Russia, in 1984 there were only three universities training very few psychologists, whereas in 2013 more than 300 institutions graduate more than 5000 psychologists (Mironenko, 2013). This increased interest is a good sign, but, unfortunately, the labor market has not adapted fast enough to provide enough jobs, thus pursuing a career in psychology turns out to be a risky choice.

Many clinical psychologists have started working in private practice as well, some also practicing psychotherapy, in various approaches (e.g., cognitive-behavioral therapy, psychoanalysis, humanistic-experiential approaches, etc.). The accessibility of their services to the general population remains relatively low due to high costs (combined with lower incomes compared to western societies) and to the fact that in many cases, psychological services (including psychotherapy) in private practice are not covered by the national insurance policies. However, this situation has started to change to some degree. For example, starting 2014, in Romania, clinical assessment and counseling (and psychotherapy for autistic children) are now covered by the national insurance system for children and adults with various psychiatric and somatic disorders (www.copsi.ro), although the administrative procedures are still unclear to most practitioners and insurance covers only a very small number of sessions. Also, in Romania, psychotherapy costs are not paid by the insurance system directly to psychologists/psychotherapists, but can only be delivered through the medical system (i.e., therefore, psychotherapy can be covered when delivered by a psychiatrist or by a psychotherapist, when he/she is the employee of a psychiatrist in private practice or works in the medical system).

Even more restrictively, in Russia, clinical psychologists are only allowed to practice psychotherapy when cooperating with medical doctors, and only psychiatrists can obtain an official license to practice psychotherapy. In practice though, many psychologists do provide psychotherapy, often under the label "psychological counselling", which is not liable to licensing, although it is established as a training program. Therapeutic modalities which have been increasingly popular in later years are psychoanalysis, existential and humanistic psychotherapy, and cognitive-behavioral therapy. Psychotherapy remains yet inaccessible to most people, since costs are not covered by the health insurance system, and mental disorders are usually treated with medication alone (Kholmogorova et al., 2013). Also, apart from the insufficient financing, there seems to be a shortage of well-trained specialists, and a lack of coherence in the system of training, supervision, licensing, and certification. Last but not least, the general population, but also healthcare policy makers are not well informed about the usefulness of psychological work, as mental health problems have belonged almost exclusively to the field of psychiatry. However, some positive changes have occurred as Russian scientists have started to collaborate with Western colleagues to a larger extent. For example, the Moscow Research Institute of Psychiatry has recently collaborated with the US Institute of Mental Health in introducing a program for the detection and treatment of depression in primary care which has increased the use and visibility of psychotherapy in the field of mental health (Kholmogorova et al., 2013).

Overall, the accessibility of psychological services varies between Eastern European countries, as their economic situation is also discrepant (i.e., some countries have been a part of the European Union for a while and have better economies than others), and varies within countries as well, being more accessible to the newly rich and forming middle class in urban areas (Ritsher, 1997).

For a more comprehensive picture, we will briefly describe psychotherapy services available for the population in several central and eastern European countries, as described by the Network for Psychotherapeutic Care in Europe (http://www.npce.eu/), a joint effort of mental health care representatives from different European countries interested in improving the practice and accessibility of psychotherapy at an international level.

Czech Republic

In the Czech Republic, psychotherapy services are financed via multiple insurance systems, either in hospitals, day clinics, or outpatient care. Patients who don't have an insurance can access psychotherapy services in private practice, and this option is also available for insured patients who wish more personalized services (e.g., therapy provided by a particular professional). The most widespread treatment modalities are cognitive-behavior therapy, eclectic, integrative, psychodynamic, gestalt, and family therapy (Vybíral, 2011). Insurance systems cover treatment modalities indiscriminately, depending only on the contracts they sign with different professionals. Patients can be recommended to follow psychotherapy when diagnosed with psychiatric disorders, but also somatic disorders where psychological factors are involved, and also when dealing with stressful life events. Additionally, patients can choose their therapist from a list of licensed professionals, but there is some limitation by the session quotas covered by insurance companies. The insurance companies also differ with respect to how much they cover, and there are also differences in practice between different regions in the country and between large cities and rural areas.

Hungary

In Hungary, psychotherapy services are available for the population in hospitals, day-treatment and outpatient facilities. Sessions are covered by the national health insurance system, and there are 16 psychotherapeutic methods accredited and supported with no restriction. Most common methods are cognitive-behavioral therapy, dynamic therapy, family therapy, psychodrama and other humanistic approaches, and there are no constraints on using particular methods for particular disorders. Patients in out-patient care can choose sessions and methods freely as long as they

have an indication for psychotherapy (i.e., for affective disorders, anxiety disorders, eating, somatization, sleep disorders, personality disorders, etc.). In most cases, inpatient psychotherapy sessions are delivered in a group format, but the opportunity for individual psychotherapy also exists. However, private practice services are not included, which limits the available services for patients, and there are large differences between cities and the countryside, since psychotherapists prefer working in urban areas, thus increasing the accessibility problem (Harmatta, 2011).

Latvia

In the case of Latvia, psychotherapy in public health care is mostly restricted to medical professionals, who practice mainly psychodynamic approaches, following a specialization in psychotherapy. Requirements and guidelines are regulated by the Latvian Ministry of Welfare, but there are no such regulations for private practice. Patients can access psychotherapy services for various conditions, but the accessibility remains, overall, limited (Lucava, 2011).

Poland

In Poland, psychotherapy services are covered by the national health insurance system and by private insurance companies as well, and are offered in hospitals, day center units, and outpatient care. Psychotherapy is recommended for various conditions, like affective and anxiety disorders, eating, sexual, personality, sleep, psychotic and somatic disorders, and for emotional and behavioral disorders in children and adolescents. Treatment modalities supported by the national health fund are cognitive-behavior therapy, integrative psychotherapy (e.g., person-centered, psychodynamic therapy, gestalt), and family therapy. However, in order to choose a particular therapist and benefit from an unlimited number of sessions, one has to turn to private practice services (Jaraczewska, 2011).

The Current Training System and Licensing

Psychology has become a popular field of study for many young people in Eastern Europe, especially after the fall of the Iron Curtain. There are now many psychology programs training students from bachelor level to doctoral and post-doctoral level, in different areas (e.g., clinical psychology, work and organizational psychology, educational psychology). The duration of these programs varies, as some countries, part of the EU, have adopted the Bologna training system (involving a 3 years

program for bachelor's degree, 2 for master's degree, and 3 for Ph.D.), while others have not. Also, psychologists in the EU states and nine other European countries have the possibility of applying for a EuroPsy (http://www.europsy-efpa.eu), a European Certificate in Psychology allowing work mobility of psychologists within the EU. The EuroPsy is a system including education, training and ethical standards which have to be met by psychologists in order to apply (i.e., a 5-year or more academic education in psychology, 1 year of supervised practice, provide evidence of current professional competence, subscribe to a statement of ethical conduct, engage in continuous professional education). It does not offer licenses (since these are nationally established), but a certificate attesting professional competencies of psychologists. Not all countries in Europe have implemented the system, but many, including some from the former Eastern Bloc (e.g., Czech Republic, Hungary, Russia, Slovenia).

In many cases, the formal requirements with respect to education for becoming a clinical psychologist are not yet clearly established and/or enforced, since the work market has not yet been consistently correlated with the higher education system. For instance, in many fields, not only in psychology, one enters the profession (e.g., becomes psychologist) once she completes a bachelor's degree, and master or doctoral studies are not compulsory. For some professional qualifications, master's degrees are compulsory, while doctoral studies are still pursued mostly by those who want to continue a career in research or academia. So, how does one become a clinical psychologist in Eastern Europe?

Since it is difficult to offer updated information on all countries in the former Eastern Bloc, we will exemplify with the situation in Romania (for more details, see David, 2006/2012), briefly describing some of the systems in other countries as well. As previously mentioned, in Romania, psychology as an academic field was prohibited starting the 1970s, and was reestablished only in 1990, so many educational and professional standards, as well as legal frameworks had to be designed from scratch. The law regarding the status of the profession of psychologist passed in 2004 (Law no. 213/2004); the law outlines the attributions and obligations of psychologists regardless of specialty, so, technically, clinical psychology, educational, organizational psychology are not different professions, but different specializations within the field of psychology. Also, one becomes a psychologist after completing a bachelor's degree (undergraduate level). Education can continue to master's degree and doctoral degree, but the formal qualifications are still general (i.e., one gets a doctoral degree in psychology, not clinical psychology). In order to practice as clinical psychologists, psychotherapists, educational psychologists and so on, psychologists have to register with the Romanian Board of Psychologists, established and recognized by law in 2004, an organism responsible for establishing and enforcing professional and deontological standards. Registration with the Board is not compulsory by law in order to practice psychology, but nowadays employers prefer registered psychologists, especially public institutions, and most practicing psychologists are registered with the Board (the Board includes about 30,000 Romanian psychologists, for a population of about 20 million).

At first, one can become a clinical psychologist (i.e., registered with the Board of Psychologists) once he/she completes the bachelor's degree, entering the field *in supervision*. Once supervision is completed, they can become *autonomous* clinical psychologists, afterwards (after 5 years of practice at least), they can become *specialist* clinical psychologists, and, later, after 10 years of practice, *principal* clinical psychologists. Although one can become a registered psychologist after obtaining a bachelor's degree, in order to advance (i.e., become *autonomous* and further), additional academic and practical training is needed, in the form of a master's degree or an equivalent program.

Once a clinical psychologist, attributions refer to psychological testing and assessment, as well as psychological intervention, but for instance, psychologists are not entitled to perform an ICD or DSM based diagnosis with legal implications, without the countersignature of a psychiatrist. At this point, it is worth mentioning that clinical psychology is distinct from psychotherapy in Romania. In order to become a psychotherapist (registered with the Board of Psychologists), one has to complete a training program, lasting for at least 2 years, offered by an accredited (i.e., by the Board) professional association. These associations represent and teach within different theoretical paradigms (e.g., cognitive-behavioral, psychoanalysis, experiential) and are private (usually NGO's) enterprises, not state-level (a situation similar to other countries, like Bulgaria). To conclude, there is a legal framework and a licensing system for clinical psychologists in Romania and most practicing psychologists adhere to it, but psychologists can (and some still do) practice the attributions of a clinical psychologist or psychotherapist without being registered to the Romanian Board of Psychologists. If not licensed by the Board, how can these psychologists be held accountable? For once, they are accountable by law (which refers to psychologists in general, not only to those registered with the Board), and by the ethical codes of the institutions they work in. In practice, this lack of unity in professional standards still creates confusion although things seem to be moving in the right direction.

The situation seems somewhat less clear in Serbia, with graduates receiving the same title, at all levels, regardless of the specialty they study, and the profession of clinical psychology existing in practice, but not being legally recognized. Unlike Romania, in Serbia, psychologists working in health care institutions hold the title of "health associate" at first, and then have the opportunity of enrolling in a specialization of Medical Psychology (which is a postgraduate course at the Medical School). There is no institution similar to the Board of Psychologists (which has professional authority in some matters, as recognized by law), but Serbian psychologists can register at the Association of Psychologists of Serbia, which is a voluntary, professional, and scientific organization, assembling about 20% of psychology graduates.

In Poland, although psychology as a scientific and practical field has a long (and almost uninterrupted history), the profession was formally recognized by the government in 2001. Interestingly, the code of ethics for the profession has been established prior to the legislation, in 1988, and updated in 1991. Currently, standards for

the profession are outlined by two professional organizations. The Polish Psychological Association sets professional standards and enforces the code of ethics, and the Committee of the Psychological Sciences of the Polish Academy of Sciences sets standards for the education and training of psychologists, publishes a scientific journal and organizes scientific conferences. When graduating training in professional psychology in Poland, psychologists can obtain two titles: psychotherapist and clinical psychologist, the latter working mostly in hospitals (Welfel & Khamush, 2012).

In the Czech Republic (unlike Romania and Serbia), *psychologist* is legally recognized as a profession in four different fields, including health sector—"registered clinical psychologist", and private practice—diagnosis and counseling in psychology. There is a license needed to enter these fields and, in clinical psychology only, a revalidation of the license to practice is needed after 10 years (National Awarding Committee (NAC) for EuroPsy in Czech Republic: Overview, 2013).

Summary

To our knowledge, there are many professional associations for clinical psychologists and psychotherapists throughout Eastern Europe, but their credential systems are not always correlated with state legislation, and government based professional standards are still not clear enough. Professional boundaries are still being formally defined, and, in the public eye, the situation appears even more confusing; probably also due to a lack of mental health culture, people are not sure when to see a psychologist (not to mention what kind of psychologist), how they differ from psychiatrists, and what kind of services they offer. However, the situation differs widely among countries, as some have better resources than others, and as some countries managed to continue their scientific tradition during the communist regime (e.g., Poland), while others had to develop the field of psychology almost from scratch (e.g., Romania). Also, there are wide discrepancies within countries as well, with people from richer, urban areas accessing psychological services much more often than people in rural areas. Therefore, the gap between and within Eastern European countries is rather wide, with psychological services becoming increasingly more popular and familiar to the public in some regions than in others.

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Latin America

Carmem Beatriz Neufeld and Anelisa Vaz de Carvalho

Introduction

Latin America (LA) refers to Latin American countries that were colonized by Portugal, Spain or France. The term *latin* originates from the Roman languages that are derived from Latin, including Spanish, Portuguese, and French. Geographically, LA refers to a broad region encompassing the vast majority of countries in South and Central America: Argentina, Bolivia, Brazil, Chile, Colombia, Costa Rica, Cuba, El Salvador, Ecuador, Guatemala, Guyana, Haiti, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Puerto Rico, Dominican Republic, Uruguay, and Venezuela (Nuñez, 1972; Klappenbach & Pavesi, 1994; Nuñez, 1972). Although these countries share similar linguistic elements (with respect to its origin) and have some cultural and historical elements in common (e.g., slow socioeconomic development, stories of colonial exploitation and totalitarian regimes), they are vastly different in their social, cultural, economic and historical characteristics (Wolf, 2011). Among other things, the differences are related to the geographical location that determines the business contacts and the communication with other Latin countries and countries from other continents (Sosa & Valderrama-Iturbe, 2001). In addition, there are internal differences; Brazil, for instance, is the only Latin American country that adopted Portuguese as opposed to Spanish, which is spoken in all the other countries of the same continent. Moreover, because of its large territory, there are large cultural, ethnic and linguistic differences (M. Silva, 2000). These differences have a direct impact on the practices and on the degree of professionalization, education, and scientific/technological development in each country. In general,

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countries with higher economic resources tend to have greater investment and development in research and professional training, which is the case in Argentina, Brazil, Colombia, Mexico, among others (Sosa & Valderrama-Iturbe, 2001). This is also true for Psychology. Therefore, as noted by C. Silva (2013), unity seems almost utopian for such a diverse continent. However, despite its diversity, it is important to understand the history of LA in order to appreciate the development of psychology (Ardila, 1968). Whereas some regions are advanced, others are still in the early or late stages of development (Sosa & Valderrama-Iturbe, 2001).

The advent of psychology in Latin America, as has happened elsewhere in the world, was based on two aspects: the first was grounded on a medical model, where psychology was at the service of medicine; the second, on the philosophical model, which aimed to study the soul (Ardila, 1968; Moreira, Romagnoli, & Neves, 2007). The course of the historical development of psychology in LA, in turn, can be divided into two periods: the first, between the nineteenth and twentieth centuries, when the first university-level institutions were developed, societies and scientific journals were founded, and psychological knowledge began to be applied in various areas (criminology, medicine, education, social, etc.), and the second, from the early twentieth century to the present, with the creation of university courses for professional training of psychologists (Gallegos, Berra, Benito, & Lopez, 2014).

Some historiography researchers claim that the advent of psychology in Latin America occurred around 1898, with the first Psychology laboratory, in Argentina (Ardila, 1968; Klappenbach & Pavesi, 1994). However, the advent of scientific psychology in Latin America has its beginning at the end of the second half of the nineteenth century, in countries such as Argentina, Chile, Mexico, and especially Brazil, with positivism, characterized at this time by the experimental method (Klappenbach & Pavesi, 1994; Massimi, 1990).

During this period, clinical psychology was not so widespread, remaining in the institutional perspective, aimed at public service—in the scope of criminology, within psychiatric hospitals, and in the field of education (Klappenbach & Pavesi, 1994). However, at the same time, French psychology strongly influenced the construction of the paradigm of experimental psychology, positioned, along with behaviorism and psychoanalysis, as the three most influential schools (Klappenbach & Pavesi, 1994; Massimi, 1990).

It was only in the late nineteenth century, and early twentieth century, that clinical psychology was definitively established in Latin America, venturing into problems of an individual order in the context of experimental psychology; such as had occurred in France, and unlike institutions in Germany and in the United States (Klappenbach & Pavesi, 1994). Thereafter, the history of clinical psychology in Latin America gradually developed.

In Brazil, psychology was first influenced by Waclaw Radecki, a Polish psychologist who founded the first Brazilian psychology laboratory at the Pontifical Catholic University of Rio de Janeiro (PUC—Rio) in 1923. In Peru, Walter Blumenfeld, a German psychologist who worked in the field of education, and directed the Experimental Psychology Institute of the Universidad Nacional de San Marcos in 1934 was also a great influence. Then, successively, in Mexico, Chile,

Venezuela, Colombia, and other Latin American countries, gradually, psychology also became a discipline and a profession during the first four decades of the twentieth century (Ardila, 1968).

Later, between 1947 and 1953, Colombia, Chile, Cuba, and Brazil, respectively, were the pioneers in creating careers or psychology departments in Latin America (Ardila, 1968; Massimi, 1990), while the recognition of clinical psychology as a profession occurred only in the 1950s and 1960s (Klappenbach & Pavesi, 1994).

In 1968, a period in which there was an emphasis on utilitarianism and pragmatism, clinical psychology was greatly expanded in the region: Latin American psychology was greatly interested in psychotherapy and psychological assessment, leading to the growing development of applied psychology; while scientific, experimental, and theoretical psychology received less attention (Ardila, 1968; Massimi, 1990). Also during this period, Freudian psychoanalysis still had a great influence on Latin American clinical psychology, since the Rogerian approach was not given much space, unlike what happened in the US at the time (Ardila, 1968).

In Argentina there was a hegemony of psychoanalysis, even though it was not followed by other Latin American countries that were slowly breaking with this model, such as Colombia, which began to focus on experimental psychology, Peru, which focused on a humanistic and psychometric approach, and Venezuela, which gradually began to make room for social and cross-cultural psychology, and especially for behavior modification (Klappenbach & Pavesi, 1994), through the study of operant conditioning (Ardila, 1968).

With respect to clinical practice, one can observe that its consolidation occurred primarily in Argentina and Brazil. Twenty years after the first psychology class graduated clinical psychologists in Brazil represented 42% of professionals in the field (30% were represented by organizational psychologists, 21% worked in the education sector, 17% became lecturers, and 17% did not engage in the profession) (Presti, 1978). A survey conducted only in Buenos Aires indicated that 66% of professionals were engaged in clinical psychology in Argentina (Litivinoff, 1970 cited by Klappenbach & Pavesi, 1994). These rates, however, were more conservative in countries such as Mexico, Venezuela and Peru, where educational psychology still prevailed (Klappenbach & Pavesi, 1994).

Psychology and Military Regimes

Years before, in 1947, the American Psychological Association [APA], in the US, had determined that the training of the psychologist should include both professional and scientific instruction, aimed at the diffusion of psychological practices marked by scientific rigor and standards (APA, 2006; Shakow et al., 1947). This recommendation should have been favorable, some years later, to the dissemination of behavioral-based therapies, given that their fundamental characteristic is the practice based on empirical evidence; however, cognitive-behavioral therapy [CBT], for example, developed in the 1960s, was faced with obstacles to its development in Latin America, between the

decades of 1960 and 1980, remaining behind the psychoanalytic hegemony that had settled in Latin American universities.

In the 1970s, however, Latin America was ruled by military regimes that directly interfered in the context of universities and were in some way opposed to intellectual and scientific development. At the time, the following countries were ruled by the military: Argentina (1976–1983), Brazil (1964–1985), Bolivia (1971–1982), Chile (1972–1982), Ecuador (1972–1979), Haiti (1971–1987), Nicaragua (1936–1978), Paraguay (1954–1989), Peru (1968–1975), and Uruguay (1973–1985) (Coggiola, 2001).

In Bolivia, for instance, political changes were decisive in the development of psychology, which ceased over a long period, due to the military coup of 1971, responsible for closing the doors of universities for 2 years (Aguilar, 1983). Chile and Argentina also faced a decline in the development of psychology over this period, as many researchers had to immigrate to other countries because of political persecution, which led to the revitalization of psychoanalysis, as in the case of Mexico (Sosa & Valderrama-Iturbe, 2001). Furthermore, Cahbar (2015), specifically looking at the situation of behavioral therapies in Latin America, points to the fact that the military regime in Chile strikingly impacted the development of CBT: the professors in this area were persecuted in Chilean universities, erroneously seen as leftists, due to their revolutionary ideas for psychology.

In short, the political and economic establishment has always been categorical in influencing the development of psychology in LA, not only during the dictatorships; in Paraguay, for instance, the late development of psychology was also largely due to the wars; during the twentieth century, for over 70 years, the country was plunged into wars—War of the Triple Alliance (1864–1870) and the Chaco War (1932–1935)—which resulted in economic instability and successive reconstructions, leading to a delay in the investment in education, culture and technology (Coppari, 2011).

The political context of the 1970s greatly influenced the advent of theoretical approaches that lie at the core of empirical practices (dependent on an efficient scientific training offered by universities), such as CBT. A priori, it is important to note that the APA does not establish a continuum of “best and worst” theoretical approaches and does not recommend the use of any specific approach; however, it is known that the Cognitive Therapies, born within empirical research (Beck, 2013; Hofmann, 2014), have in their scope the determination of performing Evidence-Based Practices [EBP] perhaps more intensely than other theoretical approaches (Melnik & Atallah, 2011). It is believed, therefore, that the late development of behavioral-based therapies in Latin America has its origin in the difficulties regarding the political and economic establishment that universities experienced in the 1970s, culminating in the perpetuation of the more traditional approaches.

Despite military rule in Latin America over this period, in the late 1960s and early 1970s clinical psychology had undergone rapid growth. However, besides the military coups restraining scientific and technological development, there were still other major difficulties to overcome: one of them involved physicians’ opposition to people working with psychotherapy without a medical degree, even though medical

students did not get any training in psychotherapy during their graduate studies, unlike psychologists (Ardila, 1968). This was more intense in Argentina, due to the influence of the Argentine Medical Association (Ardila, 1968; Keegan, 2015). In 1968, Brazil, in turn, already relied on the legal recognition of the professional psychologist (regulated by federal law since September 1962) (Filho, 2004); while in Argentina and Mexico he/she was not as yet recognized. Nevertheless, these three countries already had strong training programs in psychology, with a large number of psychologists having clear definitions of their functions and acting in the clinical field (Ardila, 1968).

Psychology in the 1970s was also marked by an increased interest in the study of basic cognitive processes, where many research groups were formed (in Brazil, the group including Maria Coria-Sabini, Antonio Penna and Maria de Moura; in Argentina, Hours Romoldi, Miguelina Guiao and Luis Lara-Tapia; and in Mexico, Gustavo Fernandez and Javier Aguilar). However, as had been occurring in the context of clinical psychology, owing to political issues and the lack of economic resources in Latin America, the development of research was limited due to difficulties in the purchasing of materials and equipment (Sosa & Valderrama-Iturbe, 2001).

Globalization of Psychology

In 1991 the Southern Common Market [MERCOSUR] economic block was created. From an economic point of view, the block aimed to unify its member countries, however, through its advent, there was also an attempt to unify professionals in the field of psychology (C. Silva, 2013). Since 1994, psychologists and institutions from the MERCOSUR countries—Brazil, Argentina, Uruguay and Paraguay—gave rise to a joint policy, in order to set standards for the integration of professional practice and to develop the construction of a reference of Latin American psychology; in the following years this move was followed by Chile and Bolivia (which joined MERCOSUR), creating the Coordination Committee of MERCOSUR and associated countries [CCPM] (Cáceres, 2008).

Meetings of the CCPM intended to create a self-identity of Latin American psychology, through debate and the creation of ethical, political and economic agreements for the professional practice of psychologists in MERCOSUR and associated countries, as well as discussion of strategies to improve the quality in the training of psychologists and the circulation of services and professionals, common to the reality of its member countries (Cáceres, 2008).

Then, in the late twentieth century and early twenty-first century, regarding the theoretical approaches, psychoanalysis in Latin America had different levels of acceptance. In the early 2000s, in Argentina, the psychoanalytic approach was fully accepted in the clinical setting, while in other countries there was a partial acceptance of its theoretical concepts, such as in the case of Mexico, or a relative indifference, as in Cuba and Nicaragua (Klappenbach & Pavesi, 1994; Sosa & Valderrama-Iturbe, 2001). In Latin America, there was also a strong interest in

cross-cultural, social and political psychology, especially in Cuba, Peru, Mexico, Colombia, Venezuela, Argentina and Ecuador - probably fostered by the social, economic and political organization of these countries (Sosa & Valderrama-Iturbe, 2001).

The experimental analysis of behavior also had its landmark in LA in the 1960s: in Brazil, with the visit of Fred S. Keller to the University of Brasilia (UNB) and in Mexico, with the visit of BF Skinner to the Congress of Behavior Analysis in 1975—expressing the recognition of Latin American behavior analysts (Colotla & Ribes, 1981). These exchanges between Latin America and the US encouraged the increase of production and scientific events in the area, and also supported the further development of cognitive-behavioral therapy, especially in Brazil, Colombia, Mexico, and later in Argentina (Sosa & Valderrama-Iturbe, 2001).

Considering both the historical and the contemporary context of the continent, we can observe that Latin American psychology has widely developed in regard to research and clinical practice, but it is still based on internationally defined themes (Gallegos et al., 2014; García, 2006; C. Silva, 2013). Indeed, Latin America has always faced complex political, historical and social conditions; nonetheless, its production and growth have never stopped, such as occurred with the history and development of Latin American psychology.

Research and Academic Environment

Most Latin American psychologists choose their field while still undergraduates (which lasts on average 5 years). During this period, they receive a varied schedule of training in different job possibilities, including clinical psychology. Once in the labor market, the training scenario at graduation may change or remain the same, depending on each country.

In general, psychological research in Latin America (LA) is predominantly empirical, objective and quantitative, and often makes use of objective instruments (such as tests, scales, inventories and questionnaires, for data collection); for the most part, psychological studies and research use primarily hypothetical deductive paradigms, counting on formulations of logical empiricism, although there are some large centers of psychoanalytic orientation, such as in Argentina, where this approach is dominant in scientific research. Moreover, the growing interest in Humanistic Psychology since the end of the twentieth century is noteworthy as it is often used by phenomenology, which does not reject the scientific method, but is oriented to the study of direct and immediate experience as the base of knowledge (Alarcón, 1999).

Until the 1960s, international psychology models were only virtually replicated throughout the continent, a situation that began to be questioned, debated and reformulated during the 1970s (especially by the domination of political issues in psychology). Nevertheless, even in contemporary times, it is noted that Latin American psychology is very receptive to and influenced by European psychology and,

secondarily, by other international models such as the North American model, pointing out the tendency toward a matrix of thought dependence and of foreign theoretical constructs (Alarcón, 1999).

In contemporary times, there has also been the presence of Positive Psychology in scientific production, and although its growth is not homogeneous in LA, Mexico, Chile, Brazil or Argentina, these seem to be countries with a growing increase in their production in that area (Solano, 2012).

The major criticism resting on the importation of foreign psychology models is oriented to the fact that Latin American scientific research should have, as its main task, the development of problems analogous to the social and political reality of these countries, in favor of less fortunate Latin American groups (Alarcón, 1999; García, 2006), rather than concentrating only on problems of an individual order and on the experimental practice, so that Latin psychology will be in line with its own reality and demands.

This situation, of course, also implicates the low originality of psychological research in Latin America, which often focuses on the replication or re-evaluation of international research (Cáceres, 2008; García, 2006). Especially since the late twentieth century, Latin American psychology has been dedicated to reporting results and accomplishments as well as conducting research on the associations among variables, causal relationships and experimentally manipulated variables; however, it should be noted that there is a line in Latin American psychological research that, in general, sees man as its central issue, thus differing from North American psychology, which often uses subspecies to explain human behavior (as in the case of behaviorism in the field of learning in the late twentieth century) (Alarcón, 1999).

As Arbaiza-Bayona (2012) notes, this situation primarily arises from the low Latin American tendency to conduct studies and disseminate them, since the advancement of science in a given area is also closely associated with the dissemination of legitimately produced knowledge.

Although scientific production and its publication in journals is one of the most important means of dissemination and propagation of science in the contemporary world, in LA, such production and dissemination are still scarce. Representing only 3% of the world production, it has low impact, visibility and dissemination and few citations. Thus, it is referred to as a “peripheral science” and remains behind the publications in developed countries (Arbaiza-Bayona, 2012; Ochoa Henríquez, 2004).

Hence, LA is in a marginalized position in terms of production and dissemination of scientific knowledge, especially when compared to other countries. This situation is due to the low investment in scientific research in educational systems that promote knowledge reproduction rather than trying to draw new paradigms and research, in addition to its late development and the reconstruction of universities following wars and military regimes.

Generally, in LA, as in other parts of the world, there is a strong tendency of the theoretical orientation adopted by universities to influence their scientific production. However, while LA is still submerged in the hegemony of psychoanalysis, in

some Latin American countries, the empirical approaches (cognitive and behavioral) tend to have their research results published more often, thus justifying their higher prevalence in Latin American journals. In this sense, it is important to analyze the instances "academic training" and "research."

Due to the scarcity of data on the development of CBTs in Latin America, much of the data were collected from interviews with researchers and professors, who are references in the field in their respective countries.

Paraguay

In Paraguay, it was only a little over 100 years ago that psychology began to be recognized in the country, as its introduction in Paraguayan universities occurred only in the 1960s at Universidad Católica and Universidad Nacional de Asunción (Cáceres, 2008). Since its inception, Paraguayan psychology has been marked by the psychoanalytic approach, which is very traditional in the country, and the first professionals interested in behavioral therapies within universities surfaced in the 1980s, influenced by John Throne and Daniel Escobar (Airaldi, 2015; Britos, 2015).

Indeed, currently, in Paraguay, Freudian psychoanalysis clinical practice is in the forefront, representing the first force in the country, followed by the systemic and humanist approaches, conceived by the adoption of theorists such as Freud, Rogers, Frankl, Bateson, and Minuchin, Albert Ellis and Aaron Beck (Airaldi, 2015, Britos, 2015). This context may be attributed to the lack of specific regulations in the education sector in the country, given that the Ministry of Education regulated the number of training hours, however, it did not mention the offering of therapy "classes"; therefore, the diffusion of certain approaches ends up depending on the training of professors that take over the university chairs or, in some cases, on the view that the university chooses to follow (Airaldi, 2015).

This situation leads to the maintenance of vicious cycles and the reproduction of models *ad infinitum.* Therefore, we observe that there is indeed a delay in the integration of psychology with the predominantly behavioral approaches, a fact that also generates an imbalance in the incorporation of new discoveries and scientific advances (García, 2006).

However, many professionals who seek post-graduate courses in Paraguay are clinical, school, and hospital psychologists, and they often choose CBT: it is also true that while some of these psychologists choose other approaches, they are eventually impelled to seek a theoretical approach that evidences more efficient results in the short term, as they meet a large number of patients per day (Airaldi, 2015; Britos, 2015).

But, this situation also often culminates in a *false theoretical eclecticism: "the true integrative approach or the true cognitive therapy requires a lot of knowledge about everything, but there are people who make use of techniques indiscriminately"* (M.C. Airaldi, personal communication, July 16, 2015). In Paraguay, in all the approaches there is also a predominance of eclectic practices, which primarily consist of adaptations of various procedures, without proper theoretical rigor

(Britos, 2015): there is no professional regulatory agency or law, which complicates the ideal practice of the profession; therefore, in Paraguayan psychology bad clinical practices are often prevalent (Cáceres, 2008).

In Paraguay, in academic training as well as in research, Freudian psychoanalysis is in the forefront, representing the first force in both fields, followed respectively by the systemic, humanist and cognitive approaches (Airaldi, 2015; Britos, 2015). Cognitive and Behavioral approaches are undergoing an expansion movement in many Latin American countries, however, they still face political and economic issues that permeate the universities, such as what happens to psychology itself. In Paraguay, for instance, there is a lack of investment in higher education and scientific production in order to promote the fundamental duties of higher education systems and also to train qualified psychologists (Cáceres, 2008).

In Paraguay, scientific research is not a priority and psychology is not seen as a respected science (Coppari, 2011). Overall, the Paraguayan scientific literature can be characterized by its large production of essays and reviews and by the lack of empirical studies and rigorous designs that lead to the appraisal of theoretical and traditional models of research. Also, the low production in the field of behavioral-based sciences contributes to a lack of its consolidation and innovation, resulting in a situation of "parasitism" of the international scientific output and "conservatism" (García, 2006). In a broader perspective, the quality of scientific production has been postponed and replaced by prioritizing vocational training, that is, the practices aimed at the labor market (Cáceres, 2008).

Additionally, on the one hand, the offer of post-graduate courses in psychology is weak, sparse, of dubious quality and with poor training (Cáceres, 2008; Coppari, 2011), on the other, within CBT, post-graduate courses are increasingly acquiring credibility, strength, and expansion. In the last 5 years there have been many graduate projects aimed at CBT (Airaldi, 2015; Britos, 2015).

Colombia

Regarding Colombia, the psychodynamic tradition prevailed until the 1970s, and since then, the behavioral, humanistic, systemic, and cognitive approaches have expanded in psychology programs (Anacona, 2015; Ardila, 1974). But it was in the late 1990s and early 2000s that, in fact, that country witnessed a great expansion in theoretical approaches that differed from psychoanalysis, which was when a large number of graduate programs in clinical psychology arose (Anacona, 2015).

Nowadays, in Colombia, there is a prevalence of different theoretical approaches in clinical practice, such as the systemic, humanistic, psychoanalytic, behavioral, and cognitive-behavioral theories, as well as a relative equivalence among the theoretical approaches in training programs. In a survey conducted by the Network of Institutions of University Services of Psychological Care [ISUAP] including 26 universities, the following results were identified: Systemic (12) Humanist (15) Psychodynamic (15) and Cognitive-Behavioral (21), showing that, currently, in Colombia, as part of internship programs in psychiatry, the psychoanalytical,

behavioral, cognitive and systemic approaches are equivalent—specifically and notably (Anacona, 2015; Camacho, 2015).

Notwithstanding, with regard to scientific publications from Colombia, due to its methodological bases, clinical psychologists of CBT have a greater tendency to present the results of their empirical studies (although representatives of other approaches have begun showing a similar trend in recent years) (Anacona, 2015).

Uruguay

As in other Latin American countries, psychology in Uruguay was influenced by psychoanalysis, however, despite being slightly ahead, its relevance and visibility compared to CBT is almost equivalent (Lagos, 2015). In Uruguay, similarly, since the origins of psychoanalytic theory, many authors investigated and contributed to the development of psychology and, gradually, in the late 1980s began to incorporate contributions to the cognitive-behavioral model, influenced by of Hugo Trenchi and Hugo Silvera (Lagos, 2015).

In turn, over the last 15 years, Uruguay, has seen, a significant growth in behavioral-based therapies; nevertheless, psychoanalysis still exerts greater influence on training courses in Psychology and even the residence programs in Psychiatry. Psychoanalysis is still defined as the main, or sometimes only, theoretical orientation and, the training internships, for example, are usually oriented either in this approach or in the social community approach; additionally, the psychoanalytic approach also represents most of the publications in the country (Lagos, 2015).

Panama

In relation to Panama, according to Caropreso (2015), until 2003 the model of greatest influence in the country was psychoanalysis, which has progressively been replaced by behavioral-based approaches due to the influence of the presence of professors from the United States, Argentina, Mexico and Chile in the country.

Presently, psychoanalysis and CBT are currently the first two main forces in the country, followed respectively by the systemic, gestalt, and humanist approaches. Also, in the academic setting of Panama, the most commonly adopted approaches are CBT and psychoanalysis, practiced by the precepts of Aaron Beck, Albert Ellis and Sigmund Freud (Caropreso, 2015).

Dominican Republic

Regarding the Dominican Republic, the psychodynamic hegemony still remains, and the consolidation of behavioral- and cognitive-based approaches are still rather incipient, where the first association in the country is currently being created,

through the formation of the Dominican Association of Cognitive-Behavioral Therapy (Rodriguez, 2015).

In undergraduate courses in Psychology in the Dominican Republic, cognitive-based approaches are offered in a few universities, however, there are not highly qualified professors and, similarly to the post-graduate courses in psychology, psychological training focuses on psychoanalytic, systemic and behavioral approaches (Rodriguez, 2015).

Additionally, clinical practice in the Dominican Republic is marked by the systemic family—psychoanalytic, humanistic, and behavioral—under the theoretical precepts from those such as Bowen, Minuchin, Virginia Satir, Freud and Rogers (Rodriguez, 2015).

Argentina

Historically, the practice of Argentinean psychology faced great obstacles since its beginning: while in 1966, in Britain, there was a law revoking the physicians' exclusive right to conduct psychotherapy (especially psychoanalytic), in 1967, Argentina approved a law contrary to that, restricting the right of physicians to practice psychotherapy. It was only in 1985 that the right to practice psychology returned to the psychologists, who requested to "turn the legitimate into legal" (Keegan, 2015).

In Argentina, the psychoanalytic tradition lasted almost exclusively until approximately 1980. After this period, the country's psychology lived the influence of the French school, with the front of experimental psychology that paved the way for behavioral-based approaches (Keegan, 2015). According to Asociación Argentina de Terapia Cognitiva [AATC], it was only in the late 1980s and early 1990s that the cognitive approach, for example, was brought to the country through the propagation of the "standard models" of Cognitive Therapies (AATC, 2015; Keegan, 2015), especially by the influence of Hector Hernández Álvarez, who founded the Aigle Foundation—a group that would study the cognitive model (Hernández-Álvarez, 2015).

The history of Argentine psychology also had important highlights in 1995: Eduardo Keegan was responsible for creating the first Chair in CBT within the Universidad de Buenos Aires, which until then was almost exclusively Lacanian (AATC, 2015). Nevertheless, in Argentina, a minority between 20% and 30% of professionals currently work with CBT, while about 50–60% of psychologists have a specific interest in Lacanian psychoanalysis; on the other hand, despite the climate of competitiveness and tension between CBT and Lacanian psychoanalysis in Argentina, it is clear that CBT strongly outweighs this other approach in the private sector (Keegan, 2015).

Interestingly, for many decades, being "a psychologist" in Argentina was synonymous with "being a psychoanalyst," contrary to what was happening in Britain, where such representation was given by behavioral psychology and/or experimental. However, despite the growing psychoanalytic hegemony in this country, psychoanalysis faces issues related to poor practices in the approach: currently, many

professionals who identify themselves as psychoanalysts have no formal training in the area, i.e., they have no expertise or formal title (Keegan, 2015).

In a broader perspective, as evidenced in Paraguay and in many other countries, Argentina also suffers from a poor clinical practice that is not restricted to a particular theoretical approach. Currently, among psychologists, there is a growing supply of alternative practices that are not officially regulated, investigated or substantiated theoretically and scientifically, yet they acquire fame and generate great profit (Keegan, 2015).

Keegan (2015) notes that, generally, at graduation, in Argentina, the training of the psychologist is predominantly Lacanian, however, in recent years, there have been opportunities for internships, master's and PhD studies in CBT—especially at the Universidad de Buenos Aires in the latter two instances.

Argentine psychology associations are not as strong/expressive; many of them are focused on psychoanalytic and systemic approaches, but there is also the presence of a CBT association (Hernández-Álvarez, 2015).

Chile

Chilean clinical psychology is conceived through psychoanalysis, which represents the first force in the country, followed respectively by cognitive, systemic and humanistic approaches (Cahbar, 2015). Between the 1980s and the 2000s, CBT was a major force in Chile, but it has since lost its position given the development of new approaches that have spread around the country, with a few exceptions, such as the Universidad de Chile, where its superior effectiveness has been evidenced by[?] new and ongoing assessments (Cahbar, 2015).

CBT, next to psychoanalysis, and the systemic and humanistic approaches, currently makes up the curriculum of the majority of Chilean universities and their studies in Psychology undergraduate courses and residency in psychiatry (Cahbar, 2015).

El Salvador

Regarding El Salvador, the acceptance of behavior-based approaches is higher than that of psychodynamics; however, scientific research is scarce in both fields: research is almost non-existent and little support is given to research in the country. Also, there are only two master's degrees in clinical psychology across the country (Mendoza, 2015).

In El Salvador, until the early 1990s, psychoanalysis was absolute in the country; however, CBT progressively grew under the influence of foreign professors from the USA and Italy, becoming equal with it in the 2000s and, subsequently, overcoming it: in the clinical context, since the 2000s, CBT has been the first force (followed by psychoanalysis and the systemic approach), and it is estimated that 60% of the country's psychologists work with this approach, under the precepts of Aaron Beck

and Albert Ellis (3rd generation practices are not consolidated yet in the country). However, the situation of CBT in the country is sensitive: many professionals use it, but they do not have expertise in the area, considering that the proper training demands not only access to theoretical content, but also hours of supervision and practical training (Mendoza, 2015).

Brazil

In Brazil, the training of psychologists, in general, comprises 5 years of undergraduate studies. Throughout this period, the student will attend theoretical and practical training where the subjects offered usually vary according to each university, but which are usually geared toward the following practices: clinical, organizational, educational, hospital, diagnostic assessment, career guidance, etc. In general, at the end of the course, the student obtains the title of "psychologist" (for the so-called "training courses in psychology," that are characterized by, in addition to theory, a great workload of practical activities) or "bachelor in psychology," however, conducting theoretical and practical scientific activities (involving the drafting of a monograph) can also grant the title of "licensed" to the student. Among the countries mentioned, most have similar training in psychology, where the graduate can work in any area, even clinical psychology, without necessarily seeking to acquire additional expertise for such activities.

Additionally, in the academic segment, many professional training courses have emerged in recent years, especially in the south, southeast, and northeast of the country. These consist of *lato sensu* post-graduate courses, lasting between 360 and 560 h, and should be supported and/or offered by universities and certified by the Ministry of Education of Brazil [MEC], granting the psychologist the title of specialist in clinical psychology.

Similarly to other countries, it is noted that CBT in Brazil has a strong tendency to disseminate its data in scientific journals and national and international conferences, often more frequently than the other psychology approaches (Shinohara & Figueiredo, 2011). This again reflects the very methodological foundations of behavior-based approaches, based on the principles of EBP.

In 2009, a study by Neufeld, Xavier and Stockmann (2010), which aimed to map the psychology courses offering CBT training in the states of São Paulo and Paraná, showed that in São Paulo, among the analyzed courses (representing 50% of existing courses in the state), 74% offered at least one subject of CT/CBT, 15% offered some content related to CBT and 11% did not offer any content, while in Paraná, 45% of the mapped institutions (which only accounted for 35% of higher-education institutions that offered training in psychology in this state) offered at least one subject related to CT/CBT, 44% did not cover CBT among their theoretical approaches, and 11% offered some content related to CT/CBT.

A study of greater magnitude, covering all Brazilian states, directed by Neufeld, Carvalho, and *Equipe de Investigação TCC-Brasil* (in press) showed that in the academic setting this approach has experienced a continuous growth process, but

the presence of Psychoanalysis, and the Behavioral, Humanistic, and Existential approaches are still quite prevalent in psychology courses.

According to the Federal Council of Psychology [CFP], Brazil has 267,998 psychologists today (CFP, 2015). In Brazil, as in most of Latin America, the practice in clinical psychology has always been strongly guided by psychoanalysis (Neufeld, Carvalho, & *Equipe de Investigação TCC-Brasil*, in press); however, in recent decades, a movement of expansion of CBT has been observed.

The delayed consolidation of behavioral-based approaches in Brazil, 20 years after its emergence, can be attributed to the fact that this period relied on limited information technology resources, difficulties of access to the international scientific literature (Rangé, Falcone, & Sardinha, 2007) in addition to the prior establishment of military rule, which lasted for many years, and led to the stagnation of scientific and academic progress.

Generally, in Brazil, despite the usual predominance of "psychoanalytic acceptance" to the detriment of cognitive and behavioral approaches by training courses in psychology and by psychologists, there is a tendency towards an increased acceptance of the cognitive practice by the medical profession and institutions. Also, such as in Argentina, the population itself has recognized its efficiency, reduced time, and straightforwardness as favorable characteristics of what they are seeking.

Although the cognitive clinic probably represents the third theoretical force in Brazilian psychology, it has been increasingly growing, becoming prominent and consolidated. In general, the dissemination and reliability of CBT have presented evidence that it will continue to expand in the country. This can be attributed, primarily, to the credibility and quality of the national scientific research, which has been promoting its results, as well as to the dissemination by the media and specialized publications (Shinohara & Figueiredo, 2011).

In general, one should not overlook the fact that often scientific and clinical psychology also develop in terms of prevailing power, interests, research lines and topics, as well as of academic dynamics marked by competitiveness and power relations that, in turn, end up perpetuating their own interests instead of social needs and priority policies, leading to a situation of stagnation that opposes the development of this area (Gallegos, Berra, Benito, & Lopez, 2014).

Summary

It is clear that in the practice of clinical psychology in Latin America psychoanalysis prevailed over other theoretical approaches until the end of the twentieth century. Since then, other theoretical approaches have been gaining ground and prestige among professionals and scholars.

In general, the scientific practice in Latin America, due to its political and economic context, still presents great challenges to be overcome: universities' shortage of economic resources and the "reconstruction" of universities whose development

stopped during years of military dictatorships, among other factors, have a direct effect on the construction of psychology and its theoretical orientations. The current scenario in the vast majority of Latin American countries has an impact not only on the amount and quality of academic research and in the training of professionals, but also in the clinical practice.

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South Korea

Sunyoung Kim and Hyun Kim

Clinical Psychology in South Korea

Korean clinical psychologists recently celebrated the 52nd anniversary of establishing clinical psychology in Korea. Like many other disciplines in Korea, clinical psychology experienced compressed growth in the past 52 years, adapting to the boundless and rapid changes in Korean society. Although clinical psychology in Korea began as it was introduced from the Western culture, the search for its own unique identity is constantly evolving in the context of dynamic Korean culture.

The Korean Clinical Psychology Association (KCPA) defines clinical psychology as an academic discipline that is aimed to aid conceptualization and treatment of clinical conditions, particularly in the context of psychological disorders. Clinical Psychology guides assessment of the psychological disorder and development of its treatment. Licensure in clinical psychology is the highest level of acknowledgement provided by the KCPA. The central roles of licensed clinical psychologists are assessment and psychotherapy along with consultation and education. Licensed clinical psychologists in Korea have the authority to perform clinical practice, administer assessment, and supervise trainees in medical settings and other clinical settings.

Currently, mental health care in Korea consists of the practice of five main types of professionals: psychiatrists, clinical psychologists, counseling psychologists, social workers, and counselors (art therapists and general practitioners, etc.). Clinical psychologists emerged later than other groups and still remain a relatively small professional group in Korea (about 1,000 master's level licensed clinical

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psychologists as of 2015 and 6,133 members in the KCPA as of 2016). However, as described in the next history section, Korean clinical psychology has developed with great intensity, diversifying its roles and areas.

This chapter aims to provide history and systems of Korean clinical psychology, the general ideas on where Korean clinical psychology currently stands, and where it should be headed for the future development. In the next section, we will briefly review the history of clinical psychology in Korea. Next, we will describe the licensure, training procedure, and clinical assessments in Korea. Then, the current status of Korean clinical psychology will be presented followed by challenges and future direction.

History of Clinical Psychology in South Korea

The Western concept of clinical psychology was introduced into Korea as early as the 1940s (Rhi, 1985), however, psychotherapy was not widely practiced until the 1950s after the Korean War (1950–1953). The use of various psychological assessments by Korean and American psychologists during the Korean War had promoted the need for an advancement in applied psychology, which had consequently increased research and practice in clinical psychology. Interest in clinical psychology as an academic field also increased during this time. Several major universities established psychology department along with formal courses in clinical psychology. In the 1960s, several Korean psychiatrists completed psychoanalytically oriented training from foreign institutions, mainly from Germany, Japan, and the United States and brought with them the concept of psychotherapy when they returned to Korea. They later became pioneers of psychotherapy in Korea and then became leading supervisors and teachers of psychotherapy for succeeding professionals in the field including clinical and counseling psychology.

As Korean clinical psychologists gradually consolidated their position in mental health institutions throughout the 1960s, the need for education and training for the qualification of clinical psychologists also became a critical concern. The Korean Psychological Association (KPA) (established in 1946) created a subdivision entitled the Society of Clinical Psychology in 1964, which is active until the present day under the name Korean Clinical Psychology Association (KCPA). The association has been publishing the Korean Journal of Clinical Psychology since 1967 and has shared various clinical and theoretical findings in the field. To continue its efforts to produce professional clinical psychologists, the association also enacted a qualification exam in 1971 and has been holding annual licensure examinations until the present day.

Clinical psychology in the 1970s was marked by an establishment as a distinguished field. As public interest in clinical psychology somewhat increased, more effort was put into training and practicing psychotherapy. Psychologists with doctoral trainings (mostly obtained in the United States) also returned to Korea and collaborated with home-trained psychologists in advancing clinical psychology as a professional field. Various internship programs were also

developed during this time, and clinical psychology became firmly grounded in the combination of scientific basis and clinical services. From 1974, the KCPA began to issue clinical psychology license to produce more psychology professionals in mental health field.

Practice of psychodynamically focused psychiatry declined in the early 1980s due to a rising popularity of biological psychiatry and psychopharmacology. Korean psychiatrists began to perceive psychotherapy by psychologists as a threat to their position in the field of mental health, especially after they witnessed the growth of clinical psychology in the United States. Consequently, the demand for psychotherapy by psychologists began to plummet in psychiatric institutions, but the primary role of clinical psychologists remained to be administration of psychological assessments. It was not until 1996 that psychiatrists were the only group of mental health professionals who had the privilege to legally practice psychotherapy in South Korea (Kang, 2002). The Mental Health Act was enacted by the Ministry of Health and Welfare in 1997 to ensure fair treatment for individuals with mental illness, and the Ministry started to provide the national license to clinical psychologists. Other governmental (i.e. Ministry of Employment and Labors) and private organizations (e.g., Ministry of Employment and Labors and the KCPA) also began to issue clinical psychology licenses to produce more psychology professionals in mental health. Given that pioneers of psychotherapy were largely psychoanalytic in orientation, early generations of clinical practice received training primarily in psychoanalysis. Nevertheless, Korean therapists who are trained in more recent years receive training in a variety of theoretic approaches.

Types of Licensure in Clinical Psychology

Currently, there are three types of licensure in clinical psychology that one can obtain in Korea. These types can be broadly categorized into government-issued certifications and KCPA-issued certification. Categorization of these licensures and institutions that mediate these qualifications are summarized in Fig. 1.

The Ministry of Health and Welfare first established a program in mental health clinical psychologist ("*jung-shin-bo-gun-im-sang-sim-li-sa*") in the mid-1990s and currently issues two levels of licensure: Level 1 primarily given to a master-level psychologist and Level 2 mostly obtained by a bachelor-level psychologist. In order to become a mental health clinical psychologist, one must receive training at a government-designated site (e.g., public mental health institutions). The Ministry of Health and Welfare also strictly regulates a number of mental health clinical psychologist that are produced each year. Nonetheless, obtaining this licensure is greatly advantageous in that it is largely acknowledged by the government as well as various mental health institutions across the nation, and therefore is highly popular and competitive among graduate student trainees. In the mid-2000s, the Human Resources Development Services of Korea (a sector of the Ministry of Employment and Labor) initiated a program for licensure entitled 'National

Fig. 1 Types of Licensure in Clinical Psychology

Technical Qualifications of Clinical Psychologists' ("*im-sang-sim-li-sa*") to train more mental health professionals and meet the needs of national policy that aimed to prevent various psycho-social problems. Similar to the mental health clinical psychologist, the clinical psychologist licensure has been issued in two levels (Level 1 and Level 2). However, the qualification issued by the Ministry of Employment and Labor is has been criticized for a lack of curriculum in training and less rigorous regulation in training sites. Therefore, it has lost popularity among newly trained clinical psychologists and is commonly viewed to be insufficient when applying for positions that require more expertise in psychotherapy.

Private licensure is issued by private institutes or associations and is categorized into registered licensure or government-certified licensures. The registered licensure requires a formal application procedure of associations and is a form of approval or permission to function as a licensing organization. The KCPA is a registered private institute, and therefore, autonomously issues private licensure in clinical psychology professional ("*im-sang-sim-li-jeon-moon-ga*"). The association is making efforts to conform the licensure program to a government-certified program, in which the qualification procedures will be recognized and respected as a national licensing system (Y. Lee, personal communication, October 17th, 2016). Although most of the training curricula have been adopted from the Western countries (particularly from the United States), there are key differences in the courses of training and degrees required to become a licensed clinical psychologist. The comparison between the education and training procedures between the U.S. and Korea are presented in Fig. 2.

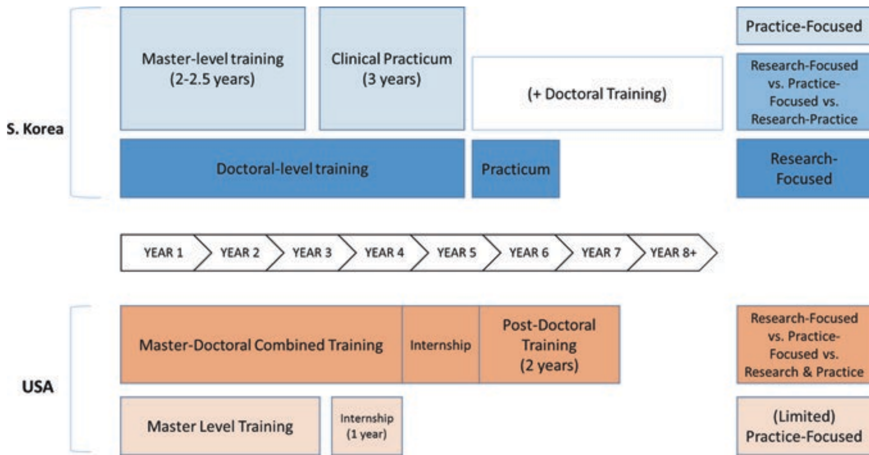

Fig. 2 Comparison of clinical psychology trainings in S. Korea vs. the United States (Note: This table was taken and translated from work by Korean Clinical Psychology Association (KCPA) Vision 50 Planning Committee (2016))

Qualifications of Clinical Psychologists

According to the KCPA regulations, licensure in clinical psychologist requires a graduate degree (master's or doctoral degree) in clinical psychology and a completion of 3 years of clinical training under a KCPA-accredited psychologist's supervision (2 years of training if the applicant holds a Ph.D. degree). In general, becoming a licensed clinical psychologist does not follow one general path. Applicants may follow specific guidelines based on their final degree in clinical psychology and previous attainment of licensure in clinical psychology from other institutions (e.g., certificate in community mental health psychology or licensure in the U.S.). Table 1 summarizes the standard procedures of qualifying as a licensed clinical psychologist, as suggested by the KCPA.

In order to be considered a KCPA-accredited clinical psychology major, one must complete ≥3 graduate courses (9 credit units) in clinical psychology or related field and ≥1 course(s) (3 credit units) in research methods. Completion of these courses must be approved by the KCPA Clinical Training Committee ("*soo-ryun-wui-won-hwe*") after submitting a graduate transcript. The list of courses suggested by the KCPA as pertaining to clinical psychology or research methods is presented in Table 2. Courses that contain alternative titles should be reviewed and approved by the Clinical Training Committee after submitting the course syllabus and going through a review process.

Qualification and training components of the Level 1 mental health clinical psychologists are very similar to those of the KCPA-qualified clinical psychologists.

Table 1 Qualification of a licensed clinical psychologist

A. Individual who holds (1) a master's degree in clinical psychology and (2) a 1st level licensure in community mental health counseling and received 3 or more years of supervised clinical practice in a KCPA-approved institution is eligible to apply for the "Professional Clinical Psychology (Im-sang Sim-li Chun-mun-ga)" licensure examination. The licensure will be issued if the individual passes the oral portion of the licensure exam (Note: These individuals are waived from the written exam)
B. Individual who is in the course of a Ph.D. degree in clinical psychology (e.g., Ph.D. candidate) and has received 2 or more years of clinical supervised training under a licensed psychologist can apply for the "Professional Clinical Psychology (Im-sang Sim-li Chun-mun-ga)" licensure examination. The licensure will be issued if the individual passes both oral and written portions of the examination
C. Individual who has received a Ph.D. degree in clinical psychology and completed ≥1 year of supervised clinical training can apply for the "Professional Clinical Psychology (Im-sang Sim-li Chun-mun-ga)" licensure examination. The licensure will be issued if the individual passes the oral portion of the licensure exam
D. Individual who received a master's degree in clinical psychology and obtains a clinical psychology license issued by a professional clinical psychology society in a foreign country can apply for the "Professional Clinical Psychology (Im-sang Sim-li Chun-mun-ga)" licensure examination. The licensure will be issued if the individual passes the oral portion of the licensure exam

Note: Summary of material available at the Korean Clinical Psychology Association (KCPA) website (http://www.kcp.or.kr/sub02_5_1.asp?menuCategory=2)

Table 2 Suggested courses in clinical psychology

Clinical psychology courses	Research methods courses
• Advanced clinical psychology	• Statistics in psychology
• Psychopathology	• Research design
• Clinical diagnosis (assessment)	• Data analysis
• Psychotherapy	• Multivariate analysis methods
• Clinical practicum	
• Neuropsychological assessment	
• Behavioral examination	

There is also a large overlap of clinical settings in which the two types of licensures are acknowledged. Individuals who obtain master's or higher degree of education and complete 3+ years of practicum at a KCPA-accredited training site may qualify for the two licenses simultaneously. While both types of licensure certify one's qualification as a professional clinical psychologist, the mental health clinical psychology licensure enacts stricter training and supervising curriculum that predominantly focuses on mental illness, and therefore, some government or state mental health centers mandate this qualification when hiring clinical psychologists. Further explanations on the mental health clinical psychologist are presented in the KCPA website (http://www.kcp.or.kr).

Training Procedures

Graduate Education in Clinical Psychology

Although there are several models that describes the current educational training models of Korean clinical psychology, it is generally agreed that professors who train graduate students employ the scientist-practitioner model that follow the training model of the United States. However, given that the majority of the students entering clinical psychology pursue clinical practice at the end of their training, many leading psychologists are becoming increasingly aware of the need to expand training opportunities in the practitioner-scholar model, (Korean Clinical Psychology Association (KCPA) Vision 50 Planning Committee, 2016). The most recent suggestions made by the Korean Clinical Psychology Association (KCPA) Vision 50 Planning Committee (2016) state the following:

> The KCPA and its members should first consider the establishment of education-training model. This model should serve to meet the current objects and roles of Korean clinical psychology, and this work should consider needs and opinions of trainees. Ultimately, the education training model needs to be diversified, separating models that focus on practical field work from models that will emphasize medical-academic settings. Sufficient discussion should be made with clinical supervisors, another large part of educational training. (p. 4).

A limitation in the current education and training model is a lack of doctoral level trainees. According to a recent report published by the KCPA, only 14 out of 525 registered trainees (2.7%) in 2014–2015 academic year consisted of individuals who obtained doctoral degree in clinical psychology (Korean Clinical Psychology Association (KCPA) Vision 50 Planning Committee, 2016). These numbers indicate that the current system is heavily focused on master-level clinicians who primarily conduct clinical work. Nonetheless, a large number of multi-disciplinary projects and lead supervisory positions require doctoral-level psychologists, and a modification in the current training system should be made to reflect an increasing demand for more doctoral level clinical psychologists in the field. While there is no combined masters and doctoral program in Korean clinical psychology, establishment of such curriculum may enhance simultaneous certification as a clinician and attainment of a doctoral degree.

Clinical Practicum

Formal clinical training comes after the attainment of graduate degrees in clinical psychology or related majors (master's level or doctoral level). This process begins with one's registration to the KCPA as a trainee at a KCPA- approved practicum site. Such training sites provide supervision by a licensed clinical psychologist professional and commonly include medical centers that contain psychiatry or

neuropsychiatry department, student counseling centers within college setting, counseling centers, and public mental health centers. Trainees are required to receive supervised clinical training for 3 years (2 years for doctoral level trainees). At least 1 year of this process (≥1000 training hours) must be carried out in one of the critical training sites ("*pil-soo-soo-ryun-gi-gwan*"), a KCPA-approved site that can provide direct and consistent supervision by at least one full-time licensed clinical psychologist or supervision by two full-time associate clinical psychologists who could provide some supervision. The critical training sites must be able to provide sufficient training opportunities in areas pertaining to research, didactics, practicum, and supervision. These sites traditionally included medical settings with psychiatric divisions, but have expanded to include educational settings, adolescent clinics, addiction centers, and business corporations in the past 10 years. Forensic sites, such as the federal court, prisons, and juvenile courts, have also offered trainings to clinical psychology trainees by becoming critical training sites. A detailed list of requirements needed to pass clinical training is presented in Table 3.

When clinical training is complete, trainees go through a formal evaluation process (Training Completion Evaluation; "*soo-ryun-wan-ryo-sim-sa*") based on their training notes that were constructed throughout their practica. These notes contain all activities during clinical training (e.g., assessment and treatment) along with signatures of their supervisors. The Clinical Training Committee of the KCPA reviews the training notes and determines whether the trainee has completed all curricula successfully. A passing score on this evaluation is a requirement that the

Table 3 Training requirements for licensure exam in clinical psychology

Psychological assessment	300 or more hours during the 3-year training period (30 or more must be a comprehensive assessment accompanied by a written report)
Psychological treatment	300 or more hours during the 3-year training period (50 or more hours of supervision)
Case presentation	2 publications/presentations (a total of 4 or more hours)
	1 publication/presentation can be substituted by oral or poster presentations at an academic conference
Manuscript publication	1 manuscript as a first author
	• If the manuscript is a portion from a master's thesis, publication in a Level A Korean journal (e.g., APA, SCI, and SSCI journals) would be acknowledged. Publication in the KCPA-recognized journal may qualify during the training period
Conference attendance	20 or more hours of attendance in an academic conferences and 10 or hours of attendance in case conferences
International/extra institutional collaboration projects	30 or more hours of the training period
Ethics training	1 or more attendance to an ethics course at the KCPA or other academic conference

applicant must fulfill before taking the licensure exam and therefore is conducted in December of every year, prior to the written portion of the license exam (held in February).

Licensure Exam

The licensure examination is conducted in two parts, the written and the oral exams. The basic course in the written exam is consisted of a wide range of psychology topics, including personality psychology, cognitive psychology, biopsychology, and research methods. In contrast, topics included in the clinical course of the written exam are more specific to clinical psychology and include psychopathology, clinical assessment, and psychological treatment. Passing of the license exam is determined by an average score of 60 or greater on the total written exam and an average of 40 on both basic and clinical sections. The oral exam is conducted in an interview format, with members of the licensure examination committee. After all exam procedures are completed, test results are reviewed by the committee members, and the licensure is issued when more than half of the committee agrees on the passing of the applicant.

Theoretic Orientation in Training

Korean therapists tend to experience difficulty in directly applying a Western theoretical orientation in the Korean setting, and therefore turn to more flexible approaches. The most widely reported orientation is eclectic approach, where a combination of familiar traditions are incorporated to the Western concepts and theories in order to better attune to uniqueness of Korean clients (Rhee, 1995; Rhi, 1985). According to comparative data of therapists from various ethnic backgrounds, Korean therapists were less likely to engage in a strong endorsement of theoretical orientations. The clectic approaches of Korean clinical psychologists may be also due to clinical psychologists' exposure to multiple theoretic orientations during their training period. For example, most of the curriculum in academic settings is determined by professors who received education from foreign institutions, particularly from the United States, and trainings during graduate education is likely focused on cognitive-behavioral therapy (CBT) or acceptance and commitment therapy (ACT). Students who are trained to use these skills later proceed to external training in medical or counseling settings and are commonly exposed to alternative theoretic orientations (e.g., psychodynamic approach) by their licensed supervisors. Therefore, a lack of continuity or consistency in theoretic orientation could make it difficult for trainees to adhere to one particular orientation, and they consequently develop more mixed, eclectic approaches to treatment by the end of their training.

Clinical Assessments

The function of clinical assessment is to analyze an individual's functioning in various domains (e.g., occupational, interpersonal, and self-development). Administration of psychological assessment is a privileged and specialized role of clinical psychologists, and a wide range of tests enable clinicians to evaluate an individual's performance on multiple domains. Similar to the Western clinical psychologist, clinical psychologists in Korea administer various types of clinical assessments, ranging from a comprehensive psychosocial assessment, intelligent test, aptitude test, neuropsychological evaluation, dementia screening, and learning disability tests. Most commonly used tests include mental status evaluations, personality tests, neuropsychological batteries, and behavioral observations. Clinical psychologists skillfully select and utilize various assessment tools to aid their clinical judgment on the diagnoses of complex and subtle clinical presentations that cannot be obtained solely from medical interviews or imaging techniques. While a large portion of assessment inventories were adapted from Western countries, many of the currently used tools were developed by Korean mental health professionals and have been standardized in the Korean population. Broadly, the types of assessments that are conducted by clinical psychologists can be categorized into personality, intelligence/cognition,

Personality assessment: Objective personality assessments in Korea include the Minnesota Multiphasic Personality Inventory (MMPI), Sixteen Personality Factor Questionnaire (16PF), and the Personality Assessment Inventory (PAI). The MMPI has been used as a clinical assessment and research instrument since its translation in 1963, but it went through re-translation and validation in a large normative Korean population after the validity and reliability were significantly affected by mistranslation of the initial version (Cheung, Lee, & Jin, 1963; Kim et al., 1989). In 2005, the MMPI-2 was published and replaced the pre-existing MMPI (Han, Lim, Lee, Min, & Moon, 2005). Cattell's 16PF and the PAI were also standardized in the Korean population (Kim, 2002; Yum & Kim, 1990). The PAI is largely preferred and widely used and in the areas where forensic psychologist is in high demand (e.g., detention center, prison, court, etc.). Commonly used projective tests in Korea include the Thematic Apperception Test (TAT) and the Rorschach Test (Jun, 1972a, 1972b). The Korean version of Exner's Rorschach Comprehensive System and the Rorschach Workbook by Exner are widely used in the hospital and private clinic settings (Cheon, 1983; Kim, 1999a, 1999b).

Intelligence/neuropsychological assessments: Intelligence test was first introduced in Korea as the Wechsler-Bellevue Test was first translated in 1953. In 1963, the Korean Wechsler Intelligence Scale (KWIS) was validated and published and used until the K-WAIS was published in 1992. The Korean version of Wechsler Intelligence Scale for Children (K-WISC) was developed and standardized by Yum and colleagues in 1992. The utility of neuropsychological tests flourished in the 2000s, as they became largely embedded in clinical assessments. Rey-Kim Memory Test was developed based on Rey Aditory Verbal Learning Test and Rey Complex

Figure Test, and Kims Frontal-Executive Intelligence Test (EXIT) was developed and validated (Kim, 1999a, 1999b). The EXIT is consisted of complex figure memory tests and scales of behavioral checklist and comprehensively measures attention, language, visual-spatial functioning, and memory domains. In 2003, Kang and Na developed the Seoul Neuropsychological Scale Battery (SNSB) and enabled comprehensive evaluation of neuropsychological performance (Kang & Na, 2003). The 2nd Edition of the SNSB (SNSB-II) was also published and is currently widely used in clinical and research settings (Kang, Jang, & Na, 2012). Currently, Korean version of the Wechsler Adult Intelligence Scale, 4th Edition (K-WAIS-IV) and pediatric intelligent scale, the K-WISC-IV, are standardized and widely used in various clinical settings (Hwang, Kim, Park, Chey, & Hong, 2012; Kwak, Oh, & Kim, 2012). The Wechsler Memory Scale, 4th Edition (WMS-IV) was also published and has widely used as an adult intelligence test along with the WAIS-IV (Chey, Kim, Park, Whang, & Hong, 2011).

Diagnostic assessment: The development of Korean version of the Diagnostic and Statistics Manual of Mental Disorders, 3rd Edition (DSM-III) in 1980 heightened the general interest in clinical assessments and led to a KPA-organized symposium on "Theories and Application of the Development of Psychological Assessment." Currently, the most recent and widely used diagnostic manual in Korean clinical psychology is the DSM-5, which was adapted with the U.S. and translated into Korean language (American Psychiatric Association, 2013; Kwon, 2015).

Current Status of Clinical Psychology in Korea

Public Sector

The Mental Health Act was established by the Korea Ministry of Health and Welfare in 1995, and the national licensure of Mental Health Clinical Psychologists began in 1997. The Mental Health Act defines the role of the Mental Health Clinical Psychologists as psychological assessment and psychological counseling of mental health patients and their families. Since then, the nationally licensed clinical psychologists have been expanding their fields from the traditional medical and mental health care settings to the more diverse settings in the public sector.

Around the year 2000, the nationally licensed Mental Health Clinical Psychologists were increasingly working in the various mental health related centers and departments established by or affiliated with the government. For example, the Mental Health Clinical Psychologists provide psychological assessment and psychotherapy for children, sexual violence victims, individuals with disability, and their family members in 34 *Haebaragi* children's centers throughout the country. The Korean Office of Military Manpower Administration hired a group of licensed Mental Health Clinical Psychologists to provide personality and cognitive assessment as part of examination for conscription. Other Mental Health Clinical Psychologists are hired

by the Ministry of Education and provide psychological assessment, case management, development of mental health programs, and public relations service in hundreds of *Wee* centers throughout the country. *Wee* centers are established by government to manage and reduce school violence and mental health problems in primary and secondary schools in Korea. The Ministry of Justice also hired dozens of Mental Health Clinical Psychologists in their forensic and correctional facilities in 2006, and the number of the psychologist positions are increasing. Smile Centers are another place where the Korean Ministry of Justice hire Mental Health Clinical Psychologists. There are currently six Smile Centers altogether in six major cities in Korea. The Smile Centers were established to provide support, protection, psychological assessment and treatment for victims of crimes. A small group of Mental Health Clinical Psychologists are providing psychological assessment and counseling in the Smile Centers.

Psychological Assessment

Psychological assessment is a critical part of Korean clinical psychologists' professional identity especially when they work in a hospital setting. The current reimbursement system of the national health insurance in Korea makes it more lucrative for hospitals to employ clinical psychologists as providers of various psychological testing rather than as providers of any other psychological services such as psychotherapy, training, or consultation. Therefore, most clinical psychologists hired in hospitals spend a majority of their professional time administering psychological testing and writing psychological test reports as ordered by psychiatrists. Additionally, psychiatrists' reluctance to share the work of "treatment" with psychologists seems to play a role in limiting clinical psychologists' contribution only in the area of assessment in medical center settings. Some free-lancer, part-time psychologists take orders of psychological testing from individual clinics and get paid per psychological testing service. This type of set-up seems to be preferred by newly licensed young psychologists who try to balance between various roles of psychologists and other responsibilities in life.

Translation, validation, and standardization of major psychological testing instruments have always been strong in the history of clinical psychology in Korea. The DSM, MMPI, WAIS, and WISC have been translated and/or standardized for Korean population whenever updated versions were published in English. During the last two decades, the PAI (Personality Assessment Inventory), MMPI-2, WAIS-IV, and WISC-IV have been translated and standardized in Korea (Chey & Kim, 2016). The Korean version of the ASEBA (The Achenbach System of Empirically Based Assessment), and K-WMS-IV (Korean Wechsler Memory Scale IV) were standardized and marketed (Oh, Lee, Hong, & Ha, 2007). Additionally, Exner's Comprehensive system for the Rorschach Inkblot Test and Exner's Rorschach workbook were translated into Korean and published. The Rorschach Inkblot test is currently one of the most commonly used instru-

ments in Korea along with the WAIS, WISC and the MMPI (Refer to the "Clinical Assessments" section of this chapter for more details regarding Psychological Assessment in Korea).

Korean clinical psychologists not only translated/standardized but also developed new psychological testing instruments for Koreans. For example, Yeonuk Kang and his colleagues developed the SNSB (Seoul Neuropsychological Screening Battery) II, based on the 2003 version of the SNSB (Kang, Jang, & Na, 2012).

Psychotherapy

Clinical psychologists in Korea have been constantly expanding areas and settings for them to provide psychotherapy. Medical centers and teaching hospitals were their first work place, but their major role and probably the only role at that time was psychological assessment, more specifically administration of various psychological testing. Nowadays, more and more clinical psychologists are asked to provide psychotherapy in medical centers, although their time is still mostly occupied with psychological testing. The small number of supervising clinical psychologists in those medical centers agree that clinical psychologists should be able to provide more psychotherapy for the psychiatric patients because even well-trained psychiatrists do not usually have time to provide psychotherapy. With the current health insurance reimbursement system in Korea, hospitals cannot afford employing psychiatrists to provide psychotherapy routinely.

During the last two decades a great number of clinical psychologists established independent psychotherapy and counseling centers such as *Hoyeon* Counseling Center (2001), *Maumsarang* Institute for Cognitive and Behavioral Therapies (2001, expansion and reopening) and Seoul Acceptance and Commitment Therapy Center (2014). As of 2014, there were 87 counseling centers established by licensed clinical psychologists in Korea (Park, 2016). Clinical psychologists generally have more latitude when they work in their own counseling center rather than in hospitals because they can decide how they spend their professional time such as providing psychotherapy, consultation, assessment, training, and program development, as long as they can financially sustain. However, when clinical psychologists work independently outside of a medical setting, their psychotherapy cannot be covered by the national health insurance. Psychotherapy provided in those counseling centers is deemed "service" not "medical treatment" by the law in Korea. The clients should pay the entire fee personally if they choose to receive psychotherapy outside of psychiatric clinics or medical centers. Therefore, financial sustainability is a very critical issue for Korean clinical psychologists who work in independent psychotherapy clinics.

The most widely taught orientation of psychotherapy in clinical psychology graduate programs in Korea since late 1990s, is Cognitive Behavioral Therapy, which led to rapid introduction and dissemination of the third wave behavioral therapy such as Acceptance and Commitment Therapy, Dialectical Behavior

Therapy, and Mindfulness Based Stress Reduction during the last 10 years (Park, 2016). Introduction, training and dissemination of various Cognitive Behavioral Therapy methods in Korea has been one of the major accomplishments of clinical psychologists.

Positive Psychological approaches also drew a great deal of attention starting from the year 2000 or so. This field can appear especially relevant for Koreans who are well known to have the highest suicide rate and one of the lowest life satisfaction rates among the OECD member countries.

More recently, psychological support for victims of disaster, violence, and crime became a central societal and professional issue as a result of a series of tragic accidents in Korea such as the Sewol ferry incident and the collapse of Mauna resort in 2014. A variety of psychotherapy methods have been trained and used for those victims. Again, Cognitive therapy, Exposure based therapies, Acceptance and Commitment Therapy, Mindfulness based therapies have been the leading methods. As the professional group who introduced these therapy methods to Korea, clinical psychologists are playing a major role in providing psychotherapy for the trauma survivors.

Other psychotherapy orientations such as psychoanalysis, brief psychodynamic therapy, Gestalt psychotherapy, and humanistic/client-centered/Rogerian therapy coexist with the newer Cognitive Behavioral Therapy orientation. These more traditional orientations have longer history in Korea especially with other mental health professionals such as psychiatrists and counseling psychologists. In addition, a number of supervising licensed clinical psychologists endorse eclectic approaches (Kwon et al., 2014). Therefore, when graduates of clinical psychology master's programs where they learn mainly Cognitive Behavioral Therapy, advance to hospitals or counseling centers to receive clinical training, they are likely to be supervised by clinicians who have various traditional orientations rather than cognitive behavioral. This can enhance diversity in their training while some students may feel that this stark discontinuity interferes with their consistent development.

Education and Academia

As of 2014, 40 universities in Korea have at least one professor who teaches clinical psychology and is licensed as a clinical psychology specialist by the KCPA. 16 out of the 40 programs are located in the Seoul metropolitan area. The number of clinical psychology professors in each department of those 40 universities range from 1 to 3, with only a handful of universities having more than one clinical psychology professor (Park, 2016). This is a major limiting factor for most psychology departments in diversifying courses, training and theoretical orientations offered for graduate students in their clinical psychology program.

Currently over 100 students graduate with a master's degree from those 40 universities each year. A small number (approximately one or less per year per doctoral program) of individuals receive a doctoral degree in clinical psychology in Korea as

well. Since a doctoral degree is not necessary to become a licensed clinical psychologist in Korea, a majority of graduate students in clinical psychology programs are master's degree seeking students. Those who pursue doctoral degrees are interested in working in academia, research or supervising psychologist positions. Although faculty positions in universities are extremely limited, owing to the recent boom of psychology in Korea, quite a few doctorates from Korean universities found academic positions during the last decade. Dozens of free standing clinical or counseling psychology programs have opened up during the last decade and hired new faculty members and educated a large number of students. Those free standing programs can be compared to the free standing Psy D. programs in the U.S. except that there is no accreditation system by the KCPA that can regulate the consistency of education and training.

The size of the KCPA increased exponentially during the last two decades: from 317 members in 1995 to 6133 in 2016. The KCPA academic journal (The Korean Journal of Clinical Psychology) which had published annually or biannually between 1987 and 1999, started regularly publishing four times a year from 2000 (Park, 2016). The KCPA also holds academic conventions twice a year and offers a major forum for research and clinical presentations, symposia, workshops, poster sessions, meetings and professional networking. Licensed and license seeking clinical psychologists can also receive education credits by attending the bi-annual conventions.

Industrial Sector and Entrepreneurs

A handful of large companies have in-house Employee Assistance Program (EAP) and hire clinical psychologists for their employees, but a more common form of the EAP in Korea is outsourcing. Currently the Korean Employee Assistance Program Association provides counseling and screening services for small to medium size companies on a contract basis. Clinical psychologists are one of the major providers of service along with psychiatrists and industrial counselors.

A number of Korean clinical psychologists with entrepreneurship ventured into the area of mental health related business. More traditional type is development of psychological assessment instruments, publishing, and education. One example is *Maumsarang*, Inc. This is a sister company of the *Maumsarang* Institute for Cognitive and Behavioral Therapies. This company develops or translates/standardizes various psychological testing instruments such as the MMPI and the TCI (Temperament and Character Inventory). They also provide psychological consultations and workshops. Some companies expand their businesses to more general psychological services such as consultation for education, career, and human resources management. An example for this type of enterprise is HUNO human and innovation, Inc. Their clients are not only individuals who seek psychological assessment but also universities, corporations, and parents who seek consultation and management service for their students, employees, and children.

Challenges and Future Direction

Clinical psychology in Korea made a dazzling development in the relatively short period of time since its beginning in the 1960's. Its development during the last three decades has been especially excellent in terms of quantity and quality. As of 2015, about 1,000 clinical psychologists are considered to have both licensures as Level 1 Mental Health Clinical Psychologist (issued by the Ministry of Health and Welfare) and Professional Clinical Psychologist (issued by the KCPA). This group is the clinical psychologists who have most education and longest training as they must have a master's degree in clinical psychology and minimum 3 years of post-graduate supervised clinical training. Currently there are approximately 1,700 Level 2 Mental Health Clinical Psychologists who are required to have a bachelor's degree and 1 year supervised clinical training (Park, 2016). These licensed clinical psychologists are now providing psychological services in government and semi-government agencies, medical centers, clinics, and enterprises. Training procedure and license regulations have been constantly improved and systematized.

Need for mental health professionals is ever increasing in Korea with steady decline of the stigma for psychiatric treatment and exacerbation of various mental health problems such as high suicide rates, high divorce rates and extreme competition throughout the life span. Clinical psychologists are well aware that they are not the only professional group who are expected to provide mental health services. Psychiatrists, psychiatric nurses, social workers, and counseling psychologists have been providing mental health service for a longer period of time in Korea. The strengths of clinical psychologists, compared to other mental health professionals, include focused training in psychotherapy and assessment and rigorous education in science in the graduate program (Kwon et al., 2014). As a relatively newly developed profession, Korean clinical psychologists face a daunting task of establishing their own place in the field of mental health care.

The consensus among Korean clinical psychologists is that a larger number of qualified clinical psychologists should be supplied to meet the increasing demand of the society and to become an influential professional group in the field of mental health. Several issues in educating and training of a larger number of qualified clinical psychologists are identified. First, there are not enough practicum sites for trainees. Second, the practicum sites should be diversified to include various governmental mental health centers, correctional facilities, schools, and primary care or rehabilitation departments in medical centers. Third, practicum trainees should be able to receive more psychotherapy training. Having a department clinic and offering in-house practicum during the graduate school time could be a way to ensure psychotherapy training. Fourth, accreditation procedures for clinical psychology programs and practicum sites should be established and enforced in order to achieve consistent quality in education and training. Fifth, in addition to training master's level clinical psychologists, fair attention should be paid to providing more qualified bachelor's level professionals as the demand is increasing.

There are three types of clinical psychology licensure that share similar framework in education and training principles (e.g., theory-based training in academic setting and practice-based training in clinical setting), but educational level (e.g., master-level vs. doctor level) and quantity and quality of training may differ by license type and the level of license (e.g., Level 1 vs. Level 2). Of the three, mental health clinical psychologist licensure and national technical qualifications are regulated by the government, and the clinical psychology professional licensure is issued by the KCPA. While clinical psychology as a field is making a progress to produce more clinicians and researchers, a lack of consensus on the education/training curricula obfuscates standardization of competency among clinical psychologists. The current qualification procedures are constantly reviewed by board members of each regulating branch to ensure that trainees obtain adequate clinical skills to become a qualifying therapist in the field.

The current training systems are also headed to advancement in education and clinical opportunities. At an educational level, graduate programs in clinical psychology may adopt a curriculum that combines master's and doctoral training in order to produce more research-focused doctoral level clinical psychologists. From a training perspective, diversification may happen by distinguishing practice-focused "practice-scholar" model from research-based "scientist-practitioner" model.

Many clinical psychologists in Korea agree that the roles and areas of clinical psychologists should not be limited to assessing and treating psychopathology in medical settings. All kinds of professional psychological services that can be offered by the clinical psychologist should be included in the area of clinical psychologists' work. Mental health assessment for hiring and human resource management, work place stress, psychological service in forensic settings, developing web contents relevant to mental health and adaptation, intervention for educational or career problems caused by maladaptation, family and marriage, reproductive health related issues, behavioral medicine, consultation, community intervention could be added to the more traditional role of providing psychological assessment and psychotherapy. Indeed, more and more clinical psychologists in Korea are venturing into new fields such as schools, police department, corporations, governmental agencies and consultation for business and educational institutes. The demand for clinical psychologists are also coming from diverse settings, as described in the previous section, current status of clinical psychology.

Accomplishing solid professional identity and originality has been an on-going task throughout the developmental history of Korean clinical psychology. Because establishing its own place in the field of psychology and mental health care in Korea has been most urgent, debates on training models or theoretical orientations have not been extremely active. A recent exploration among the KCPA members revealed that most graduate programs consider their training models to be the scientist-practitioner model, not unlike many programs in the U.S. However, some members raise questions about this implicit agreement, pointing out that the scientist-practitioner model may not be practical in Korea where most licensed clinical psychologists are master's level clinicians. Debates on theoretical orientations tend to

be inactive in Korea partially due to the small size of the clinical psychology community and the harmony oriented Korean culture. Also, Korean clinical psychologists may feel that having debates on imported knowledge and theoretical orientations is not the more significant task compared to developing original knowledge concerning Korean people and society. Indeed, many clinical psychologists agree that rather than simply importing European and American psychology, increased effort should be directed to conducting research on Korean populations and developing psychological assessment tools and therapy methods for Koreans.

With the recent revision of the Mental Health Act in 2016 and upcoming enforcement of it in 2017, Korean clinical psychologists are having active discussions about future directions of this field and changes to be made in the enforcement decree. Underlying philosophy of this revision is moving the focus of mental health care from the treatment of the mentally ill in the medical setting to general improvement of mental health in the community setting. The weight of mental health care is no longer solely on the medical professions. It is now distributed to multiple professions in numerous settings. This change is likely to be a positive one for Korean clinical psychologists, since they are already trained to work in and outside of medical settings, to work with diverse populations whether they are mentally ill or not, and to conduct research as well as psychotherapy and assessment.

Conclusion

Clinical psychology in Korea was established under the influence of the Western countries in the 1950s, but it has evolved and expanded to best serve the mental health of the Korean population through rigorous research and modifications. Although it is still in a time of transformation, clinical psychology in Korea is making its way to consolidate its distinction as a discipline that specializes in psychological assessment and intervention. Clinical psychologists in Korea are involved in a wide range of roles, which include assessment, diagnosis, intervention, and consultation. While they have traditionally worked in medical settings and private clinics, their field has been continuously expanding to multiple domains such as educational institutions, court systems, social service centers, prisons, and industry.

Historically, clinical psychology in Korea has been largely impacted by changes and movements in social issues, such as the Korean War or advancement of changes in healthcare dynamics. After economic collapse called the "IMF crisis" in 1997, the suicidal rate in Korea has been the highest among the OECD member countries. Furthermore, intermittent traumatic events such as the Daegu Subway Disaster in 2003 and the Sinking of Sewol ferry in 2014 have heightened public awareness in mental health, providing more weight and emphasis on psychological services. A steady rise in the suicide and divorce rates in Korea have also gradually contributed to public demand of more mental health professionals. Although it is uncertain how the current epidemics and the newly revised Mental Health Act (2016) will shape the future of Korea's clinical psychology, the roles of clinical psychologists are expected to expand to more diverse areas that cover human functioning across the lifespan.

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China

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Concept of Clinical Psychology

Definition of Clinical Psychology

Clinical psychology is an integration of the science, theory and clinical knowledge for the purpose of understanding, preventing, and relieving psychologically-based distress or dysfunction and to promote subjective and behavioral well-being and personal development (Society of Clinical Psychology; Plante, 2005). Central to its practice are psychological assessment and psychotherapy, although clinical psychologists also engage in research, teaching, consultation, forensic testimony, and program development and administration (Brain, 2002). In many countries, clinical psychology is regulated as a health care profession.

Characteristics of Clinical Psychology in Mainland China

Compared to the concept "*Clinical Psychology*" in North America, the "*Clinical Psychology*" in Mainland China is a relatively vague notion. It is always mixed up with other subject names, such as, Counseling Psychology, Medical Psychology, Psychosomatic Medicine, Healthy Psychology, Behavioral Medicine, etc. In psychology

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department of university, most of clinical or counseling related curriculums are set under Applied Psychology, a subordinate discipline of Psychology, with diverse course names. Most people who work in the area of clinical or counseling psychology have different training or education backgrounds. And many of them have not got a Master or Ph.D. degree. However, those professors or experts with Ph.D. are primarily devoted to teaching and research, but not clinical service.

Those people who provide psychological services are often called "psychological doctor". Because of the influence of traditional Chinese culture, people who are going to see a psychiatrist in psychiatric hospital or mental health center believe that they will be discriminately treated as "psychosis" or "insanity". By contrast, it's much better if they see a "psychological doctor" in a community based or college based clinics. Hence, the notions of psychiatry and psychology greatly differ from each other. The concept of psychiatric disorders is much discriminated by the society, while the concept of "Psychological disorders" is relatively much friendly accepted.

Given the limited space available, we are not to introduce the development of clinical psychology in Hong Kong, Taiwan or Macau.

History and Development

There existed rich ideas and practices related to clinical psychology before modern clinical psychology was introduced into China at the beginning of the twentieth century. In general, the development of clinical psychology can be divided into four phases as follows.

Before 1949: Initial Spread of Modern Clinical Psychology

Before the establishment of Republic of China (1911), it was the preparatory period of Chinese local clinical psychology. A variety of Traditional Chinese Medicine (TCM) classics, such as *Treatise on Febrile and Miscellaneous Diseases* (伤寒杂病论) and *Invaluable Prescriptions for Ready Reference* (千金要方), recorded many psychosomatic diseases, interpreted the relationship of mind and body, and developed some corresponding treatments. In addition to TCM, witchcraft, divination and praying magic figures were also used to provide treatment in this period (Chen, 2012).

During the period from 1912 to 1949, modern western clinical psychology entered China and began to develop. The normal pavilion of Peking Imperial University, i.e., the predecessor of Beijing Normal University, first offered a psychology course in 1902, involving a variety of topics related to general psychology, experimental psychology, child psychology, etc. The first psychology lab was established in Peking University in 1917. In 1920, the first psychology department

appeared at Nanjing Higher Normal School which changed to National Southeast University later. From 1923 to 1928, departments of psychology were founded in a few other Chinese universities including Beijing Normal University and Peking University. These psychology departments gave a number of clinical psychology courses, such as abnormal psychology, abnormal child psychology, principle of mental health, applied psychology, and so on (Gao, 2005). Moreover, mental health courses were also provided in some medical colleges in this period.

The Chinese Psychological Society (CPS) was founded in 1921 in Nanjing, and Chinese Association for Mental Health (CAMH) was founded in 1985 in Taian. Some hospitals, schools, child welfare organizations and medical research departments began to open mental health clinics, providing psychological assessment and counseling/therapy by professional psychological workers and social workers (Sun & Ji, 2010). The first mental health congress took place in 1948 in Nanjing (Gao, 2005).

From 1949 to 1976: Stagnation of Clinical Psychology

In the period from 1949 to 1965, western psychology, particularly social psychology, psychological testing and mental health, was criticized and even denied (Gao, 2005). Psychological therapy work was done only to a limited extent. For example, the Institute of Psychology of the Chinese Academy of Sciences (CAS) and Beijing Medical College cooperatively developed a rapid comprehensive therapy, combining medical treatment, physical exercises, thematic lectures and group discussions, for individuals with neurasthenia, schizophrenia and some psychosomatic diseases like hypertension and canker (Qian & Wang, 2006).

During the Cultural Revolution period (1966–1976), psychology was declared pseudoscience, and psychology courses were stopped nationwide. It cancelled the Institute of Psychology of CAS as well as psychology teaching and research sections in department of psychology of universities, resulting in the complete stagnation of psychology.

From 1977 to 2000: Restoration and Development of Clinical Psychology

The Institute of Psychology of the Chinese Academy of Sciences was restored in June 1977, and CPS resumed activities later in November 1977. In the following years, departments of psychology were reestablished in several universities including Peking University and Beijing Normal University. The Ministry of Health of the People's Republic of China (CMH) proposed to offer medical psychology course at medical colleges, and to establish psychological counseling clinics in mental

hospitals and comprehensive hospitals, providing psychological service. According to the regulations issued by the CMH, one of the rating criteria for comprehensive hospitals (first class hospitals) is whether a psychological counseling clinic is established or not. As a result, psychological counseling clinics are now available in thousands of first class hospitals nationwide.

Since 1984, psychological counseling centers have been set up one after another in universities, offering free counseling service for students (Huang, He, & He, 2008). In the following years, professional psychological counseling organizations were established in Chinese justice department (e.g., armed police, jails, and drug rehabilitation center), social service system (e.g., Disabled Federation, Women's Federations, and communities), and enterprises as part of corporate training (Huang et al., 2008).

However, a great number of problems and challenges have emerged whether in psychological counseling clinics of medical institutions or psychological counseling centers of the higher education system, of which the primary is the majority of mental health service staff lacks systematic and standard professional training.

From 2001 to Today: Rapid Development of Clinical Psychology

Former Chinese Ministry of Labor (CML) released the temporary national qualifications for psychological counselors in 2001. The first qualification examination was carried out in 2002, and psychological counselors, as a new career, can conduct related psychological counseling only when they received the qualification certificate. In addition, the CMH incorporated psychological therapy into the qualification examination system for medical professionals. Individuals who passed the examination will receive the psychological therapist qualification certificate, which is the only qualification certificate approved by the CMH, in addition to psychiatrist, for conducting professional psychological therapy. These government measures promoted the popularity of psychological counseling and therapy service in public. However, problems still remained regarding psychological counselors/therapists' professional training, continued education and management.

The Committee of Clinical and Counseling Psychology was set up in CPS in 2001. In 2007, the executive committee meeting in Beijing approved two important documents: *Chinese Psychological Society Registration Criteria for Professional Organizations and Individual Practitioners in Clinical and Counseling Psychology* and *Chinese Psychological Society code of Ethics for Clinical and Counseling Practice*. The Clinical and Counseling Psychology Registration System (CCPRS) of CPS was founded to conduct quality control and self-discipline.

The Chinese Mental Health Act was launched in 2013. It first made a clear distinction between psychological counseling and psychotherapy service, regulating that (1) psychological counselors can only provide professional counseling service for the public outside of mental hospital system, but cannot conduct psychological therapy or mental disorder diagnosis and treatment; (2) mental disorder diagnosis

should be made by certified psychiatrists; and (3) psychological therapy should be conducted in medical institutions.

Professional Condition of Psychological Counseling and Therapy

Professional Training Systems

The Discipline Subordination of Clinical and Counseling Psychology

According to the rules of Chinese Ministry of Education (CME) and the Academic Degrees Committee of the State Council, Psychology is the first-level discipline and Applied Psychology is the second-level subject, while Clinical and Counseling Psychology is the subordination of Applied Psychology. Since 1998, China has set up Applied Psychology (4 years) as one of major of undergraduate, granting "Bachelor of Science". So far, the number of colleges which set up Applied Psychology as a major is more than 200, and some universities opened courses named applied psychology.

The Training Provide in Normal or Comprehensive Universities

The department of psychology in universities resumed to recruit student in 1978. Since then clinical/counseling psychology related majors have been always welcomed by students. There are a lot of courses of applied psychology, but less practicum activities in department or school of psychology in university system. The school attaches great importance to scientific training, and the requirement of graduation for Master graduates is to publish paper on Chinese core peer review journals as first-author, and for Doctoral graduates is to publish paper on foreign core peer review journals as first-author. Only after publishing articles and finish their thesis, can students, whom no matter what programs they are, be qualified for the final oral defence. By contrast, there is no requirement of clinical related practice training by university, such as lacking of systematic, normative clinical/counseling training program and standards of practice and internship for students. As those clinical or counseling psychology professors working in university system have a whole lot different training background, most of them no clinical or counseling psychology system training, they offer no psychological service. Hence, what clinical training the students get from their schools depends on what their advisors or supervisors prefer to. In general, because of being short of practicum, internship and supervision, and other reasons, most graduates cannot be engaged in psychological counseling- or psychotherapy work.

Even so, some or a small number of clinical psychology professors themselves still insist on clinical work weekly, such as therapy sessions, supervisions and

clinical intervention research and related practice, by overcoming all kinds of obstacles. Meantime, their students are required to get some clinical training and practice as much as they can. However, for various reasons, clinical or practical training for students is still limited.

It is worth mentioning that, in recent years, a few universities have started to pay attention to the clinical psychology program enacted by CCPRS which has already put up with a definite provision about courses, academic, practicum and internship requirements, hoping great progress and breakthrough could be made in the near future.

The Training Provide in Medical Schools

Unlike North America and other countries, in Mainland China, CME approved to set up applied psychology as a specialized subject for undergraduate student in nine medical colleges in 2001 which breaking through the situation that applied psychology major was only open for students in normal/comprehensive universities. By the end of July 2009, according to the official information from the website of CME, over 50 medical colleges have set up psychology or applied psychology major (not including psychiatry) (Shen & Tao, 2005; Wang & Du, 2010). Graduates majored in applied psychology from normal or comprehensive universities can not work in hospital system because of impossibility to acquire physician certificate, while those graduates from medical schools are qualified for acquiring it.

The Training Provide in Social Institutions

Since last early 90s, several influential training programs have been successively introduced into mainland China, such as “Sino-German Advanced Continuous Training Program for Psychotherapist” (also the first continuous training program introduced into Mainland China), the counseling training program conducted by Professor Mengping Lin (learn from Carl Rogers) from Chinese University of Hong Kong in Beijing Normal University. Most of the trainee from those programs later become the professional leaders in the field of psychological counseling, bringing great influence for the initial development of provision of psychological service in mainland China.

In recent a few years, more and more training programs of different schools gradually become systematical, such as “The China American Psychoanalytic Alliance (CAPA)”, “China-Norway Continuous Training Program for Psychoanalytical Therapists and Supervisors”, “Satire’s Family Therapy Continuous Training Program”, “Cognitive-Behavioral Therapy (CBT) Continuous Training Program” by Professor. Jianping Wang of Beijing Normal University, “China-German Advanced CBT Continuous Training Program”, etc. To a large extent, above training programs offset the deficiency of the clinical practice in universities, and improved the level of psychological service. Whereas, on account of the lack of

resources of qualified supervision and solid theoretical foundation, the number of clinician with enough training to offer psychological service independently is very limited. Therefore, CCPRS has established several supervision working points in some provinces (so far about 10) where exist registered supervisors and psychological counselors or therapists.

However, besides the existence of those long-term programs, there still are many short-term trainings (a few days) in different skills or approaches in various forms. Some training teachers come from foreign countries, and some are from Hong Kong or Taiwan. On the whole, the professional level of training is still low (Yao, 2010).

The Training Program for Professional Master Students

The training program including applied psychology or mental health education for professional master degree began in 2011 for the undergraduate entrance, which is a 2-year full-time schooling education. Nevertheless, the admission standard and graduation criteria, comparing with the one for academic master degree are relatively low. The training program has no clear requirement for practicum or internship. Additionally, although some of students have acquired the *Certificate for Psychological Counselor* granted by the CML before or after their graduation, they are still not able to do the work like psychological counseling or therapy. Since 2013, some universities start to admit part-time professional master students, majoring in Psychological Counseling, Employee Assistance Program, Family education or Therapy and so on. And in 2016 fall semester, School of Psychology of Beijing Normal University is starting to conduct systemic professional clinical and counseling psychology training program, including practicum, internship and supervision hours for professional master students.

Theory Schools of Psychological Counseling

The western theories of psychological counseling or therapy, like dream interpretation and free association, were initially introduced into China at the beginning of the twentieth century, later followed by behavioral therapy in 1930s. Thus, psychoanalytical and behavioral therapy were the earliest approaches introduced into mainland China.

The real development of psychotherapy began in the late 1980s, with a few books on psychological counseling or therapy, primarily the works of Sigmund Freud, being translated into Chinese. In the 1990s, some psychodynamic therapists have already begun to independently offer psychological service. Until now, in mainland China, there are four psychotherapist certificated by International Psychoanalytical Association (IPA), and six psychoanalyst certificated by International Association for Analytical Psychology (IAAP).

It is worth mentioning that Dr. Youbin Zhong, the native psychotherapist in mainland China, pioneered Cognitive Insight Therapy, also known as Chinese Analytical Psychology, which combines the principles of psychoanalysis with Chinese national conditions and traditions. Cognitive Insight Therapy is a short-term technique and is suitable for social anxiety and anxiety disorders (Qian & Zhong, 2012). Moreover, there is another technique worth mentioning, i.e., Imagery Conversing. It is a psycho-therapeutic technique developed by Dr. Jianjun Zhu in the beginning of 1990s. Based on psychodynamic theory, this technique creatively incorporates dream interpretation, hypnosis, humanistic psychology, and eastern culture into one application. It can be used for obsessive-compulsive disorder, school phobia, depression and other symptoms (Li & Zhang, 2011).

Behavioral Therapy was initially introduced into China in 1930s, not being widespreadly applied until the 1980s. It was not until the 1980s, Cognitive Therapy was introduced into Mainland China, and some works of Aaron T. Beck and Albert Ellis were translated as a main source of teaching materials. At that time, most people learned cognitive therapy by reading books themselves, and then used certain cognitive skills in the process of psychological counseling, and thus they classified themselves as cognitive therapist. Consequently, the data showed that the number of people who using cognitive techniques is the largest. And many of them consider it easy to learn and not necessary to attend a systematic training program to be a CBT therapist. Different from what is expected, many trainees finally found that it is far away from being a cognitive behavioral therapist after participating in my CBT training workshops (first author of this chapter). Therefore, the real Cognitive-Behavioral Therapy is not developed until recent years. So far, only three CBT therapist have acquired the certificate issued by the Academy of Cognitive Therapy (ACT) and one approved as an ACT's Fellow (first author of this chapter) in Mainland China.

Although family education or therapy started relatively late in Mainland China, however, it has developed a little bit faster. The number of family counselors or therapists is only less than that of psychodynamics. In April 2007, the Ministry of Human Resources and Social Security of the People's Republic of China permitted to grant *Marital and Family Counselor* as a new career. Later in June 2009, the first career certification exam for marital and family counselor was conducted. Wai-Yung Lee, the member and supervisor of American Association of Marital and Family Therapy, now is the chief director of the Hong Kong University Family Institute. She is the only Chinese disciple of Dr. Salvador Minuchin who is the founder of Constructed Family Therapy, contributing herself into the application and development of marital and family therapy both in Hong Kong and Mainland China. In mainland, Marital and Family Therapy Institution of Beijing Normal University run by Dr. Xiaoyi Fang is the earliest professional research and therapy institution.

Quite a lot of theoretical ideas and basic techniques of humanistic psychology have been the basis of other schools. Until now, related humanistic-existential psychological trainings, also some of the Chinese version of books written by Irvin Yalom, have already been introduced into mainland. Since 2014, the

first successive 2-year professional certification course for “Humanistic and Existential Psychological Therapy”, cooperating with International Institution of Existential and Humanistic Psychology, was introduced into China. The aim of this course was to assist domestic psychological counselors and therapists to better know the essence of existential-humanistic psychology and apply it to their clinical work.

In the year 2015, among the whole applicants in CCPRS, more than 70 persons applied for psychoanalyst or psychodynamics, ten applied for family therapist, only three applied for CBT, and one applied for narrative therapist. Obviously, psychoanalyst applicants leaded an overwhelming margin.

Mental Health Service Market

Service Providers

It was estimated that there were about 16 million persons with severe mental illness, about 39 million with depression, and about 130 million with various mental disorders in Mainland China (Qian, 2009). At present, the mental health service providers mainly consist of the following ten categories of professional or nonprofessional persons, which partially overlap.

Category 1: Psychiatrists. There are 1650 mental health professional organizations, 228 thousand psychiatric inpatient beds, and more than 20 thousand (author note: about 22 thousand) psychiatrists (Centers for Disease Control and Prevention (CDCP) of National Health and Family Planning Commission of the People’s Republic of China (NHFPC), 2015). In terms of location distribution, most resources are in eastern and urban areas; and there are no professional mental health organizations in a total of 37 cities (mainly in western areas), around one third territorial area and 41.9 thousand population covered (Guo et al., 2008). Most psychiatrists have a medical background and lack systematic and standard psychological therapy training. They primarily provide mental disorder diagnosis and medication treatment, and only a few can provide systematic and regular psychological therapy service.

Category 2: Psychological therapists. Since the first psychological therapist qualification examination in 2002, nearly 3000 persons have received the therapist qualification certificate, most of whom work in medical institutions to offer psychological therapy service (CDCP of NHFPC, 2015). Moreover, a variety of training programs have been introduced from Germany, the U.S., Norway and other countries, which improved a number of psychological therapy professionals’ technical skills and service quality.

Category 3: Psychological counselors. By the end of the first half of 2016, over 1.5 million persons participated in the national counselor qualification examination, and more than 900 thousand persons received the counselor qualification

certificate (Level 2 and/or 3). Certified counselors are widely distributed in various industries, such as education, health, justice, labor/youth/women's organizations, and the army (police) system. However, due to the low entry standard in early counselor qualification examinations and candidates' various educational and professional backgrounds, even though the requirements for examination registration become stricter in recent years, the majority of certified counselors have had only a short-term course without practicum or internship training so that they can hardly provide professional counseling. A recent survey in Beijing, Shenzhen, Anhui province, Shandong province and other regions revealed that 1 year after receiving the certificate, about 8% counselors were still engaged in psychological counseling service, and no more than 3% were professionally engaged in counseling (CDCP of NHFPC, 2015).

Category 4: Registered clinical and counseling psychologists. CCPRS of CPS was founded in 2007 to explore better professional management mode. By the end of 2014, a total of 13 professional mental health service agencies registered in the system; the number of registered clinical and counseling psychologists was 726 (CDCP of NHFPC, 2015); to include registered assistant psychologists and supervisors, the total number is still less than one thousand.

Category 5: School counselors. The CME launched documents in 1999 and 2001 to promote the training and certification of school counselors in primary and secondary schools as well as colleges and universities. The requirements for candidates are teachers and owning at least bachelor degree in education or psychology. There are about 60 thousand school counselors. They mainly help students to deal with developmental and some psychological problems.

Category 6: College instructors. First as political instructors in 1952, the role of college instructors has been largely extended, particularly since 2004, to help students in dealing with study and life problems, including emotional distress, interpersonal relationships, career planning, and so on. Due to the close relationship between college instructors and students, they are often quite aware of potential mental health problems among students, take first action like communication with students, contact students' parents, help arrange counseling for students at university counseling center, and keep following up. Surveys showed that students preferred to ask help from college instructors with psychological problems, compared to psychological counselors (Chen, Wu, Zhao, & Ma, 2010). In recent years, more universities support and organize their college instructors to participate in continuous psychological therapy training programs in order to improve their professional capacity.

Category 7: TCM Practitioners and non-psychiatric doctors. A survey (Shi et al., 2000) in Shanghai Mental Health Center showed that only 50% (9/18) patients with bipolar disorder visited department of psychiatry first, and the ratio was 37% (51/138) for schizophrenia, 12% (11/91) for depression and 7% (5/74) for neurosis. Most patients received first TCM or other western medicine treatment, and about 10–28% patients received Qi Gong or Superstition treatment. One important reason why patients visited comprehensive hospitals first was the existence of accompanying physical symptoms, and other reasons included that patients or relatives lacked in

mental health knowledge and viewed first-episode psychiatric symptoms as common thought, character and emotional problems, or that they were unwilling to visit psychiatric hospitals out of fear for social stigma (Shi et al., 2000).

It is noteworthy that the role of TCM in mental health service has drawn more attention in recent years. At present, applied psychology specialty has been set up in over ten colleges of TCM, and some colleges have even master and doctor degree programs in TCM psychology. Some TCM hospitals established department of psychological counseling and neuropsychological rehabilitation ward in Beijing and other cities.

Category 8: Religious persons. Due to some psychiatric symptoms associated with strong religious superstition characteristics, the Chinese people are likely to attribute the cause of schizophrenia to supernatural forces like ghost and thus turn to religion or superstition for treatment (Huang, Shang, Shieh, Lin, & Su, 2011). Previous studies showed that 21.0–70.7% patients with schizophrenia asked for certain form of religious or superstition help (see Deng et al., 2012). Folk religion has much more influence in rural areas where mental health resources are generally insufficient, and most studies used samples from urban areas, the (positive and negative) role of religion and superstition in rural and remote areas might be more significant.

Category 9: Social workers. The evaluation system of professional standards for social workers was set up in 2006. By the end of 2013, about 760 thousand persons participated in the qualification examination, and over 80 thousand persons received assistant social workers and social workers certificates. In addition, there is not mental health social worker training or specialty. So far, a few mental health agencies in Beijing, Shanghai and other cities have founded the hospital system of social work, established independent department of hospital social work, and equipped professionals to offer psychiatric social work service (Liu & Zhu, 2011).

Category 10: Family, friends and others. There were only pharmacies where TCM practitioners also gave disease diagnosis in ancient China. In general, patients received treatment at home and the practitioners visited them regularly. In nowadays, patients receive treatment at hospital, but family members must usually stay there to take care of them. The same is true in open psychiatric ward. Patients under the age of 40 were mainly took care of by parents, and those older than 40 were usually by spouse, adult children, or siblings (Bian & Xie, 2002). Thus, family members and friends provide very important assistance in mental health service.

Moreover, local government organizations in urban communities and subdistrict as well as in rural villages play an important role in mental health service. Actually, these organizations get involved in various problems of residents, if not everything, including couple conflicts, child and old people related problems, financial difficulty, organization of various public activities, and so on. Although these organizations often deal with mental health related problems, there are few mental health professionals employed in them. Thus, to better understand the situation of mental health service in Mainland China, it is necessary to include the contribution of these non-professional mental health resources, also including volunteers in local organizations (e.g., street aunts), police (e.g., when family violence occurs), and even leaders in work place.

Service Sites

As noted above, there is currently a great lack of psychological counseling and therapy professionals, and a great number of non-professionals are engaged in mental health service. These professionals and non-professionals mainly work in the following seven areas.

Site 1: Psychiatric hospitals. It is the major force in Chinese mental health service. Psychiatrists provide treatment, in the forms of diagnosis and medicine treatment, for patients with a variety of mental disorders. Since 2002, psychological therapists began to offer psychological therapy service, as supplementary to medicine treatment, for some patients (e.g., with depression, anxiety disorder) at these hospitals. The Chinese Mental Health Act (2013) requires that specialized medical institutions for mental disorder diagnosis and treatment should also be equipped with psychological therapy professionals. Shanghai Mental Health Center has now an independent building for psychological clinic, suggesting some recognition of the importance of therapy service.

Site 2: Psychological clinic at comprehensive hospitals. The CMH required that first class hospitals must establish psychological counseling clinics in 1987. Thus, the number of such psychological clinics is very large, but they receive actually little attention from hospitals. They also generally provide medicine treatment because of incapacity to offer professional psychological service.

Site 3: Education system. At present, the comparatively highest level of professional psychological service in Mainland China should be available in psychological counseling centers at university. Universities and colleges pay much attention to students' mental health, particularly the prevention of suicide. Counseling centers were set up nationwide in all universities and colleges, and were equipped with full-time and part-time professionals. Nevertheless, only 30 thousand professionals are available to offer service for a total number of over 24 million college students (Kaiwen Xu, interviewed by Health News on July 25th, 2015). Most professionals are certified counselors, whose professional quality and skills are generally limited due to lack of systematic professional training. In recent years, psychological counseling centers have been also established in primary and secondary schools, or even kindergartens in Beijing, Shanghai, Guangzhou and other cities with rich mental health resources.

Site 4: TCM hospitals. Many people with psychological, psychosomatic, or even severe mental problems prefer to visit TCM hospitals and believe in the treatment effect of TCM. In ancient China, TCM has indeed played the role of psychological counseling or therapy to some extent. However, there exists some problems in the current development of TCM itself, and TCM practitioners vary greatly in their professional quality and skills. As a result, the potential effect of TCM on mental health problems is much reduced and thus very limited. Recently, a few TCM hospitals in Beijing, Guangzhou, Hangzhou and other cities have established department of psychological counseling, but its service quality is hard to be guaranteed.

Site 5: Enterprises. A number of large enterprises set up Employee Assistance Program (EAP) or similar section, and engage psychological counselors on site to offer counseling service for employees. However, many these counselors are often in lack of systematic professional training and sufficient professional skills.

Site 6: Private agencies and psychological hotlines. In recent years, private psychological counseling agencies are gradually increasing, varying in scale. Professionals are generally certified counselors with various education backgrounds. They primarily provide psychological counseling and hotline service for community population with psychological problems. There is little quality management and its service quality is hard to guarantee.

Site 7: Private foreign hospitals. For example, Chindex International engages certified professionals from the Europe, the U.S. and China to provide mental health services, using the American hospital standards including high price standards.

Service Delivery

Form 1: Traditional face-to-face individual session. At present, it is still the primary service form of psychological counseling and therapy.

Form 2: Online video counseling. Due to the lack of mental health resources and concentration in Beijing, Shanghai and other big cities, more and more psychological counselors and therapists provide mental health service via online video for distant visitors. In general, most counselors will not use online video to complete the whole counseling process, but rather use it as supplementary in emergencies when face-to-face session is not available. Moreover, online video is used more widely to conduct group supervision. Given the very limited supervision resources, this form of supervision plays a particularly important role. Sure, its effect is not as good as face-to-face supervision.

Form 3: Provision of psychological counselors via the Internet. It is a new trend, combining the Internet convenience into professional psychological counseling. Take the website “Jiandanxinli” for example, it is a platform which provides a list of selected psychological therapists with a detailed professional background introduction. The website users could make a face-to-face or online video counseling appointment with counselors via the platform.

Form 4: Hotlinecounseling. It is usually used as crisis intervention hotlines, and is also able to provide psychological counseling service. For example, the Maple Women’s Psychological Counseling Center Beijing offers both face-to-face and telephone counseling service for people in need. As regard to price, telephone counseling is 30–50% cheaper than face-to-face session.

Form 5: Information provision via the Internet. Recently, universities and colleges have all established their own mental health websites, and more and more medical institutions, enterprises and even individuals are setting up similar websites. The majority of these websites provide general mental health knowledge for the public, playing the role of mental health education. Many websites offer free

online information service, primarily giving answers and advices to users' questions in the form of text via BBS, Email and QQ (similar to MSN) (see Wang, Tang, Wang, & Maercker, 2012). It is actually a kind of consultation, rather than counseling. The users will be advised to visit professional mental health institutions for face-to-face sessions when needed. Some websites also provide individual counseling via telephone or QQ phone with very low price.

At present, there are still few Internet-Based Interventions (IBI) in Mainland China, i.e., providing systematic self-help or therapist-assistant psychological intervention via the Internet for specific mental problems. The authors of this chapter have recently introduced an IBI program for trauma recovery and achieved positive effects (e.g., Wang, Küffer, Wang, & Maercker, 2014; Wang, Wang, & Maercker, 2013).

Service Fee

Medical insurance system is complicated in mainland China. It covers certain kinds of medication fees (e.g., some medicines excluded and completely self-paid) and other medical costs in different percentages for different populations. Service fee is charged in various forms, mostly self-pay, and vary greatly across institutions. In general, private agencies charge highest fees; the education system offers free psychological service for their own students, but some professionals provide paid service for outside persons; the EAP service is paid by enterprises; and the psychological therapy price in hospital system is set very low so that no counseling or therapy professional is willing to do it. For example, while the price of individual face-to-face session is 120 Yuan per 50 min (about 18 U.S. dollars) in the Wuhan Hospital for Psychotherapy, local private psychological counseling or therapy agencies charge 500 Yuan per 60 min (about 77 U.S. dollars) (Jun Tong, interviewed by Health News on July 25th, 2015).

Compared to the price at Wuhan Hospital for Psychotherapy, the medical institutions in other regions charge even lower therapy fees. For example, the price is 30 Yuan per 50 min (about 5 U.S. dollars) in Beijing and 72 Yuan per 50 min (about 11 U.S. dollars) in Shenzhen (CDCP of NHFPC, 2015), but some private agencies in Beijing charge 3000 Yuan per 60 min (about 462 U.S. dollars) for psychological counseling/therapy. A psychiatrist and registered therapist and supervisor, in communication with the first author of this chapter, charged 200 Yuan (about 31 U.S. dollars) when he spent half a day doing 3–4 therapy sessions, but he could have charged more than 200 Yuan in a minute if he would prescribe medication.

Moreover, although Chinese medical insurance covers the medication fees for mental disorders, poor families can still hardly afford the systematic treatment due to the insurance's limited coverage and low level of funding. Some severe mental health problems (e.g., suicide) and treatment methods (e.g., psychological therapy) are still excluded from the medical insurance coverage; recently published *Essential Drug List* also includes very few psychotropic drugs (CMH, 2009), which is completely impossible to meet the need of offering basic treatment for psychiatric

patients (Xiao, 2009). Thus, family is still the primary provider of psychiatric patients' life and treatment fees. Insufficient medical insurance remains an important obstacle for psychiatric patients to receive timely and systematic treatment.

Clinical Assessment and Research

Tests/Scales Revision and Development

Modern testing and assessments were introduced into Mainland China in the 1910s. In the following years, some important western scales, tests and questionnaires were revised, such as the first revision (1924) of Binet-Simon Scale by Zhiwei Lu. Chinese psychologists also developed some tests, such as a Moral Will Test by Shicheng Liao (1922) (Gao, 2005). With regards to clinical assessment, Rorschach Inkblots Test and Thematic Apperception Test (TAT) were applied (Qian, 2011).

Since 1979, psychological testing has been rapidly developing, resulting in a number of revised or developed tests on intelligence, personality and capacity. Recently, with mental health drawing attention in Chinese society, the number of scales and questionnaires, for the use of assessing general mental health as well as various specific psychiatric symptoms and mental health problems, is gradually increasing. Until now, the most common scales used are still those translated from the West, such as Symptom Checklist 90 (SCL-90), Self-Rating Depression Scale (SAS), Self-Rating Anxiety Scale (SAS), and Hamilton Rating Scale for Depression (HRSD) (Qian, 2011). The most authoritative Chinese testing book is *Rating Scales for Mental Health* (enlarged edition; 1999) published by the Chinese Mental Health Journal Publisher.

In general, although psychological testing is used to screen for mental disorders in Chinese medical institutions, these tests have actually played a lesser role. It is in research rather than in counseling and therapy practices that psychological tests play a major role.

To strengthen the management of psychological testing, the CAMH founded the Committee of Psychological Assessment in 1991. In January 2008, the Committee of Psychological Testing, founded in CPS, launched a psychological testing management document, authorizing the committee to register and evaluate psychological tests, to issue and manage psychological test qualification certificates, and to certificate the organizations that publish, sell tests and offer training.

Diagnosis Tools

Chinese mental health professionals generally use three diagnosis and classification systems for mental disorders: International Statistical Classification of Diseases and Related Health Problems (ICD), Chinese Classification and Diagnostic Criteria of

Mental Disorders (CCMD), and Diagnostic and Statistical Manual of Mental Disorders (DSM). Among them, ICD-10 is the national standard for mental disorder diagnosis in Mainland China.

However, the usage of ICD-10 is less common than that of CCMD-3. Firstly, Chinese psychiatrists prefer to use CCMD-3 in clinical diagnosis of mental disorders. For example, a survey (Zou et al., 2008) revealed that among 192 Chinese psychiatrists, 63.5% used CCMD-3 as diagnosis standards, 28.7% used ICD-10, and 7.8% used DSM-IV. Second, reviewing the Chinese mental health literature, CCMD-3 is used more often than ICD-10. During the period from 2004 to August 2007, the usage ratio was 78.1% for CCMD-3, 8.6% for ICD-10, and 13.3% for DSM-IV in three top Chinese mental health journals (Chen, 2007). DSM-IV is the primary diagnosis standard in the English mental health literature by Chinese researchers. Third, since 1992, the majority of published Chinese textbooks and monographs in psychiatry more or less introduced ICD-10, and some compared the CCMD system with the DSM system in details; in chapters of specific mental disorders, however, most books used the CCMD system to illustrate the diagnosis of a particular mental disorder (Tang, 2009). Note that DSM-IV is the primary diagnosis standard in the English mental health literature by Chinese researchers.

It is noteworthy that since CCMD-2-R (1995), the CCMD system has started gradually adapting to the international classification of diseases, while retaining those mental disorder classifications with Chinese characteristics. The descriptive parts of CCMD-3 actually referred to the *Clinical Descriptions and Diagnostic Guidelines* of ICD-10, and the diagnosis parts of CCMD-3 referred to the *Diagnostic Criteria for Research* of ICD-10 and DSM-IV. As a result, the classification of diseases in CCMD-3 are greatly similar to those of ICD-10, and thus ICD-10 has a profound indirect impact on Chinese mental health professionals and practices. Given the increasing similarity between the CCMD system and the ICD and DSM systems, and more mental health professionals use the ICD system in recent years, some even question whether it is necessary to continue revising and using the CCMD system.

Research

Since the 1980s, the number of clinical psychology publications has been consistently increasing (Fu, Huang, Yin, Zhang, & Su, 2010). Besides the growth in quantity, the development over 30 years shows some significant trends.

Trend 1: On research methods, clinical trials are increasing and case reports are relatively decreasing. Take the top clinical psychology journal of *Chinese Mental Health Journal* for example, in the period from 1987 to 1997, it published about 130 articles related to psychological therapy, among which 34.6% were single case reports, 26.9% were reports of a group of similar cases, only 3.8% used the control group design to test therapeutic effect, and other 23.1% were theoretical studies (Zeng, 1997). From 2000 to 2009, the journal published 381 articles related to

psychological therapy, among which 50.1% were empirical studies (66.0% of them using the comparison group design), 38.6% were theoretical studies, and 8.1% were case studies (Mao & Zhao, 2011).

Trend 2: On research themes, while the majority of mental health publications are on therapeutic effect, only a few on therapeutic process. For example, among the 191 empirical psychological therapy publications published in the *Chinese Mental Health Journal* from 2000 to 2009, 84.3% were examination of therapeutic effect, and only 2.1% were related to therapeutic process (Mao & Zhao, 2011). The *Chinese Journal of Clinical Psychology*, another important journal in Chinese clinical psychology field, published 204 articles on counseling and therapy from 1993 to 2007, of which 41.7% were related to therapeutic effect, and only 3.4% were related to therapeutic process (Hou, Gong, Yu, & Chang, 2008).

Although therapeutic effect studies are currently dominant in quantity, these studies are still at relatively low level. First, most empirical studies used pre- and post-intervention comparisons, but much less adopted the Randomized Controlled Trial (RCT) design (Qian, 2011). Second, most of empirical studies reported the statistical significance (SS) to examine therapeutic effect. Recently, some studies reported the effect size (ES). However, few studies reported the clinical significance (CS). Given that a high proportion of clinical patients have comorbid disorders and therapeutic process is hardly standardized as in research, further research should explore new ways in which clinical practices could more benefit from the findings in RCT studies (Wang, Wang, & Tang, 2011). Third, a majority of empirical studies used scales and questionnaires to test therapeutic effect, and less studies used other assessment methods, such as physiological indicators and behavior observation. A few professors' research groups have been engaged in experimental clinical psychology all the time, and has cooperated with other research groups in brain science field to combine multiple indicators (e.g., emotional experience self-report, behavior change observation, brain function change) in experimental studies of clinical psychology (e.g., Wang, Lin, & Sun, 2002; Yan, Wang, Tang, Wang, & Xie, 2015).

Trend 3: On therapeutic approaches, the integration of different western therapeutic theories and approaches is common, and new or revised Chinese therapeutic theories and techniques emerged. A review (Fu et al., 2010) on 475 therapy and counseling publications in 11 Chinese professional journals from January 2000 to October 2009 showed that 93.7% used western theories, 4.4% used theories originated from the West but revised (e.g., cognitive insight therapy, Zhong, 1988; Taoism cognitive therapy, Zhang & Yang, 1998), and 1.3% used new Chinese therapeutic theories (e.g., TCM psychological therapy, Xu, 1994). Among the studies with western theories, 37.2% used two different theories (mainly cognitive and behavioral theories) or three and more theories (mainly cognitive, family and Morita therapy), 9.3% used cognitive theory, 8.6% used behavioral theory, and 8.4% used rational emotion theory.

Note that many publications gave a very general description of their psychotherapeutic methods; although named as some therapy approach, it could hardly be worthy of the name; in many studies it was just positive attention, explanation and support. It is particularly true for cognitive therapy and behavioral therapy that are

common in Chinese mental health publications. Most of so called "CBT therapists" name themselves as CBT therapists as they just simply practice some single cognitive or behavioral skills. But they actually what they did could not be regarded as a real cognitive therapy or cognitive behavior therapy.

Trend 4: On target population, more and more mental health publications provide psychological interventions for non-clinical populations. For example, among the therapy and counseling publications in the *Chinese Mental Health Journal* from 1987 to 1997, subjects were primarily psychotic patients and psychiatric disorders dealt with were obsessive compulsive disorder, phobia, anxiety, and so on (Zeng, 1997). During the period from 2000 to 2009, 61.5% provided interventions for clinical patients and 38.5% for non-clinical subjects (Mao & Zhao, 2011).

Professional Societies or Associations

CPS, initially established in 1921, is a non-profit and academic social organization, and becoming a member of the International Union of Psychological Science in 1980. It has 20 professional branches that cover a wide range of specialties, including Medical Psychology, Counseling Psychology. The purpose of CPS, in order to stimulate the development of psychology, is to unify national psychological workers, take academic activities, and enhance academic research.

CAMH aims at unifying national scientific workers from the institutes of mental hygiene, psychology, medical science, sociology, and education to conduct various forms of psychological education or service related activities. Since founded in 1985, there are almost 20 thousand members, and 28 local branches, subordinated by 16 professional committees, including children mental health, psychological counseling and therapy and psychological assessment. In 1997, the Committee of Psychological Counseling and Therapy of CAMH, as a group member, joined in the World Council for Psychotherapy.

Chinese Psychiatry Association (CPA), a subordinate organization of Chinese Medical Association, is the most important and influential academic society in the field of psychiatry. Its predecessor was the Neuropsychiatry Society of Chinese Medical Association which was established in 1951. Later, it separated from Neurology Society in 1994, and then became an independent institute. By the end of 2015, it has had more than 20 thousand psychiatrist members.

NHFPC has 21 organizations, one of which is the unit of mental health. In July 2015, NHFPCPRC with other related institutions together launched the National Mental Health Working Plan (2015–2020), aiming to train professional mental health clinicians including social workers, conduct standardized mental health training programs for psychiatric residents, provide continuous training programs for clinical workers, increase the number of psychiatrists, and set or improve grassroots mental health systems.

Besides above professional psychological organizations, the Ministry of Education and local Department of Education from provinces or cities also offer support and help for people or institutes in form of providing psychological services in school setting. The Department of Education is a government agency governing primary schools, middle-high schools and universities. So far all universities in China have their own psychological counseling centers, which provide psychological services for all students without any payment.

Professional Rules and Regulations

Entrance Criteria

At present, the industry entrance criteria recognized by Chinese mental health professionals are a series of criteria set up by CCPRS of CPS, based on the document of *Chinese Psychological Society Registration Criteria for Professional Organizations and Individual Practitioners in Clinical and Counseling Psychology*, including: (a) registration criteria for master's/doctoral degree training programs, (b) registration criteria for internship agency, (c) registration criteria for clinical and counseling psychologists, (d) registration criteria for supervisors, and (e) registration criteria for continuing education projects (see http://www.chinacpb.org, for more information). Note that these criteria are not established by the government and thus receive only voluntary application from individuals and institutions.

Regulations

The document of *Chinese Psychological Society code of Ethics for Clinical and Counseling Practice*, launched by CCPRS of CPS, offers professional ethics for the clinical and counseling psychologists registered in CPS as well as a basis for processing ethical complaints and inquiries initiated against the registered clinical and counseling psychologists. The professional ethical codes include seven areas in practice: (a) the professional relationship, (b) privacy and confidentiality, (c) professional responsibility, (d) assessment and evaluation, (e) teaching, training and supervision, (f) research and publication, and (g) resolving ethical issues (see http://www.chinacpb.org, for more information).

The Professional Ethics Committee dealt with the first name-identified ethical complaint against one registered psychologist (supervisor) in CPS in 2014, based on this Code of Ethics. It aroused a big repercussion in the public. By the end of 2015, the Professional Ethics Committee has received five to six cases of name-identified reports, suggesting an increasing impact of the Code of Ethics in counseling and

clinical practices. Also, a number of rules are currently being tested and improved in actual practice.

Mental Health Act

The Chinese Mental Health Act was issued in 2013, which has gone through 27 years of planning. The Mental Health Act (2013) caused great repercussions in the society. On one hand, it plays a positive role in mental health work. For example, it recognizes the importance and necessity of psychological counseling, provides the law guarantee for certified counseling practices, and also offers some rules to regulate involuntary hospitalization, guardian rights and other problems (Liu, Tong, & Zhao, 2013). On the other hand, there is a lot of controversy over it among professionals, leaving many parts to be improved in future. For example, the Mental Health Act (2013) requires that psychological counselors cannot conduct psychological therapy or make diagnosis and treatment, but it is hard to accurately distinguish between counseling and therapy in practice; and it requires that psychological therapy should be conducted in medical institutions, so that it might be suspected "illegal medical practice" to offer mental health service for persons with mental disorders in the counseling centers of schools and communities.

At present, due to lack of professional title for psychological therapists in medical institutions, there has occurred brain drain in the industry. Thus, how to foster the healthy development of psychological therapy in the framework of the Mental Health Act (2013) has become an urgent problem to resolve.

Local Regulations

Over the period when the Chinese Mental Health Act (2013) was drafted and argued, some local regulations have been developed. For example, the first local law of Shanghai Mental Health Act was issued in Shanghai in 2001. From 2006 to 2011, local regulations on mental health were also developed in Ningbo, Beijing, Hangzhou, Wuxi, Wuhan, Shenzhen and other cities (Xie, 2013).

Before the Chinese Mental Health Act (2013) was launched, these local laws have played an important role in regulating mental health practices. They covered primarily the areas of mental disorder diagnosis, clinical and experimental research, prevention of discrimination, duties of the police, legal responsibility; and also involved some content related to mental health service, psychiatric patient rights, rights of family members and other nursing staff, legal capacity and guardianship, patients' informed consent right in agent decided treatment, emergency conditions, constraints and limits, human rights protection, etc. (Di & Xiao, 2012).

Challenges and Outlook

Challenges

Since the twenty-first century, clinical psychology has entered a period of relatively rapid development, particularly in the past 10 years. However, there still exist many challenges.

Challenge 1: Insufficient professionals. As noted above, there are currently 22 thousand or so psychiatrists, about 1.6/100 thousand on average (10/100 thousand in Britain, 20/100 thousand in the U.S.). The psychiatrists primarily receive training in biomedical mode and have little psychological therapy training; the psychological therapists without a medical background are forbidden to directly receive patients in medical organizations; and there exists an inflexible boundary between non-medical organizations and medical organizations. As a result, the quantity of mental health professionals cannot meet the needs.

Based on the Chinese Mental Health Act (2013), psychiatrists and psychological therapists with a psychological background are able to conduct psychological therapy in medical organizations. However, persons without a medical background must be first employed by a medical organization and then they could have a chance to participate in the psychological therapist qualification examination. A first dilemma are currently no corresponding positions for such persons in either psychiatric hospitals or comprehensive hospitals so that they cannot be employed by medical organizations. A second dilemma is that the rules covering eligibility for the therapist qualification examination are not clear so that most provinces forbade persons with a psychological background to participate in the examination for some reason in 2015. A third dilemma is that even though persons with a psychological background enter hospitals to work, they can only get a technician position title, without promotion channel like deputy senior title and senior title. A fourth dilemma is that under the current legal framework those qualified therapists are forbidden to conduct therapy as long as they are not employed by medical organizations.

In addition, the situation is also hard for certified counselors. They vary greatly on education background, get the certificate with very low entrance standard, and receive management from different organizations. By the end of 2015, among 900 thousand certified counselors, 80–90% are part-timers and only a few really can offer counseling service.

Challenge 2: Low quality of professional service. A survey in Shanghai in 2003 showed that 18.6% of professionals in counseling organizations did not receive any training; and among those (81.4%) who received training, 48.8% received less than 3 months training and 35.8% received 3–6 months training. The insufficient professional qualities of psychological counselors and therapists lead to heavy occupational stress in themselves (Gan et al., 2007), as well as directly influence the service quality. A survey to one famous university counseling center (Hu & Jiang, 2008) showed that among randomly selected 29 cases, the average number of sessions were four. In fact, it is common that clients visited only one to two times. The cause

does not lie in therapy approaches, but in the fact that counselors have generally not received enough training. Thus, it is essential for the development of clinical psychology to consider how to provide better professional training for professionals and how to provide better supervision for them so as to improve the service quality of professionals.

Challenge 3: Chaotic professional regulations. Due to lack of mental health resources, many non-professionals without systematic training enter the mental health service industry, such as the psychological counselors with the (low standards) certificate issued by the CML. Also, a number of persons are not in mental health positions, but they undertake partial mental health service, such as the TCM practitioners or doctors in medical organizations, the college instructors in the education system, and so on. As a result, it becomes very difficult to regulate the mental health service industry. There is much confusion about the entrance criteria for professionals, service quality, service fee, and the ethics for mental health service.

It is an important step towards quality control and regulation that CCPRS of CPS was founded in 2007. However, the influence of CCPRS remains currently to be further improved in the professional field. In addition, further studies are needed to explore how professionals with different education backgrounds could be registered at CCPRS in a different classification, through what channels the qualified among the certified counselors could enter CCPRS, and how CCPRS could play a leading role in the counseling and therapy field (CDCP of NHFPC, 2015).

Challenge 4: Policies. In recent years, mental health work has drawn much more attention from the government, such as the issue of Chinese Mental Health Act (2013) and the National Mental Health Work Plan (2015–2020). However, there still lacks the necessary policy support. For example, medical institutions currently lack rules and regulations to establish department of psychiatry, develop interdisciplinary service teams, and train a fast growing group of psychological therapists. The college graduates with a psychological background can hardly be employed by medical organizations; and according to the Chinese Mental Health Act (2013), those not employed by medical organizations can neither conduct therapy nor participate in the therapist qualification examination, leaving many persons specialized in applied psychology unused. In sum, there is an urgent need for policy change and improvement.

Challenge 5: Clinical assessment and research. Although universities and colleges offer many psychological testing courses, few are related to clinical assessment. The research in clinical psychology has recently much developed. However, it has still focused on the therapeutic effect of various (western) theories and approaches, and severely neglected the therapeutic process and the unique experiences related to Chinese culture in psychological counseling and therapy. Further studies are greatly needed to examine the accountability of western theories and the validity of western techniques in Chinese culture, promote the localization of these western theories and techniques, and develop new Chinese counseling and therapy theories.

Outlook

In conclusion, the clinical psychology receives a rich thought heritage from Chinese culture with its own unique development trajectory. Through a long process of development, clinical psychology is now in the phase of rapid growing. It brings hope to clinical professionals, although they are still facing much pressure now.

We believe that, with the support of government and the guidance of professional associations, it's not far away from establishing and improving professional standards and regulatory systems, conducting standard clinical or counseling psychology training programs, formulating administration criteria for psychological graduates to work in medical system, and connecting the channels of psychological departments and medical institutes. Additionally, efforts are under way, such as adding more psychotherapy training into psychiatric residents' regular training programs, encouraging psychiatrists to get more psychotherapy training through continuous education, in order to enhance psychiatrists' ability of providing psychological services. We should allow qualified psychological professionals to do psychotherapy and run private clinics by re-interpreting current rules and making new related laws. We also should encourage psychiatrists and psychological profession also offer psychological services in general hospital, mental health center in community and other non-psychiatric institutions (Symposium Summary, 2015).

Finally, there is a need to make greater efforts to promote the registration criteria by Clinical Psychology Registration Committee of Chinese Psychological Society, including criteria for courses, internship set, supervision, training programs, and so on.

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Australia

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Introduction

The status of clinical psychology in Australia, and the health services and regulatory environment in which it operates, has been characterised by significant change across the past 5–10 years. There have been a number of catalysts for change, with the most significant being the introduction of government insurance rebates for psychologists in 2006, and the introduction of the Health Practitioner Regulation National Law Act 2009, which saw the registration and regulation of different health professions subsumed under the same legislation. This National Law also took registration and regulation from a State-based system, into a National Scheme. There are other characteristics of Australia which, although not unique, play a major role in the way in which clinical psychology services are delivered. Australia is a vast country, with an urban coastal fringe, and sparsely populated rural and remote communities. Large urban cities are in many cases huge distances apart. Australia has an indigenous population that is disadvantaged across a range of social, economic and political spheres, including access to health services. Post war waves of migration have culminated in a multicultural society resulting in a truly diverse population. Furthermore, the challenges for the profession of clinical psychology need to be seen in the context of the drive for mental health reform in Australia more generally. Five decades of mental health reform have not necessarily brought about significant improvements in the mental health and well-being of all Australians, with priority areas such as early intervention services for youth, community-based care for the acutely mentally ill, and development of services for rural and regional areas outstanding (Hickie et al., 2014). On the positive side, reforms have brought about a substantial increase in access to government funded psychology services, although

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this reform has not been without criticism. This chapter will aim to provide an overview of the profession of clinical psychology in Australia, including the historical context, training models and clinical practice, and the legislative framework under which these operate.

The Emergence of Clinical Psychology in Australia

The 1940s saw the emergence of the professional practice of psychology in Australia. It has been argued that clinical psychology in Australia has from its initial years of development, been afflicted by a lack of recognition as a specialist discipline and practice (Macmillan, 2011). Malcolm Macmillan, a Founding Member of the Australian Psychological Society, describes the very early years of growing recognition of the profession (Macmillan, 2011), when virtually all clinical psychology services were provided by state governments, and all training was at the undergraduate level. While bachelor degrees had a significant professional orientation, most psychologists learnt clinical practice in their jobs. Postgraduate training in clinical psychology was introduced gradually across the Australian states, starting with the University of Western Australia in 1956, and soon followed by the University of Sydney, in New South Wales, in 1959 (Martin & Birnbrauer, 1996). In Western Australia, clinical training was funded by the state government, with a specialist clinical professional pathway established in the public service. In Western Australia and New South Wales, a significant group of private practice clinical psychologists emerged. Specific training in clinical psychology took some years to emerge in other states, and at that time, as today, the majority of psychologists in professional practice have not completed postgraduate qualifications in a psychology specialty, such as clinical psychology.

Current training pathways in Australia have been described in detail elsewhere (see p. 5; Hunt & Hyde, 2013). Currently, the Australian model is characterised by a common undergraduate program that is seen to provide “broad foundational knowledge as well as strong skills in research methods, data analysis and report writing, upon which professional postgraduate training programs build” (p. 253, Cranney et al., 2009). Following this learning in the scientific knowledge foundation of psychology, there are different pathways to professional registration as a psychologist. Unfortunately, these multiple pathways have led to splits between those psychologists with, and those without, specialist training. For example, the 1970s saw an unsuccessful move to have specialist Colleges abolished within the structure of the Australian Psychological Society (Macmillan, 2011). Further tensions arose with the introduction of a two-tiered fee-for-service model aimed to increase access to psychology services in primary mental health care (*Better Access to Mental Health Care*) within Australia’s national health insurance scheme, Medicare, in November 2006. Under this scheme, clinical psychologists are eligible for a higher rebate, and are able to provide evidence based psychological therapies based on their clinical assessment, as opposed as being restricted to a defined list of

Focused Psychological Strategies (e.g. motivational interviewing, cognitive behavioural therapy (CBT), problem solving therapy) that can be provided by non-clinical psychologists. This two-tiered system led to antagonism between groups of psychologists, those who supported the need for specialist training in clinical psychology, and those who maintained that such specialist training was not necessary for clinical practice or for the higher rates of rebate (e.g., Carey, Rickwood, & Baker, 2009; O'Kearney & Wilmoth, 2009). Given the continuation of different training pathways to registration as a psychologist, this tension is ongoing.

The Regulatory Environment

The Health Practitioner Regulation National Law Act 2009 (National Law), was enacted on 1 July 2010, and currently governs the registration, regulation and accreditation of the health professions. While the National Law sits within a broader context of State and Territory legislation, it has brought together 14 health professions under the same legislative framework, a unique scenario that has positioned Australia as a global leader in this design of the regulatory system. With the introduction of the National Law came the consolidation of 75 Acts of Parliament and 97 separate health profession boards across eight States and Territories into a single National Scheme. The Australian Health Practitioner Regulation Agency is the body that administers the functions of registration, regulation and accreditation of the professions falling within the National Scheme, with each profession governed by a National Board. In the case of psychology this is the Psychology Board of Australia (PsyBA). The PsyBA sets a minimum standard of professional practice, and sets the minimum standard of qualification and training to practise using the protected title of psychologist. The initial Consultation Paper arising from a review of the first 3 years of the National Scheme has reported that there is widespread consensus that the introduction of the National Scheme was a "positive step forward in the regulation of the more than 618,000 Australian Health professionals who are now listed on the national register" (p. 5, Australian Health Ministers' Advisory Council, 2014). A recently commissioned independent review of the National Scheme (Australian Health Ministers' Advisory Council, 2014) has concluded that although some changes are needed to enhance the efficiency of the Scheme, it remains recognised as among the most significant and effective reforms of health profession regulation in Australia and internationally.

Registration Standards

Under the current standards set by the PsyBA, there continue to be multiple pathways that lead to general registration as a psychologist, with the qualifications required being either (a) an accredited Master's degree; or (b) a 5-year accredited

sequence of study followed by a 1-year Board approved internship (5+1); or (c) a 4-year accredited sequence of study followed by a 2 year Board approved internship (4+2). While completing these pathways, trainees are listed on the register with "provisional registration" type.

Controversy over the 4+2 (and now 5+1) models has been longstanding, with numerous critics of this training pathway to clinical practice (e.g., Geffen, 2005; Helmes & Pachana, 2006; Helmes & Wilmoth, 2002). For example, the 2 years of supervised practice is characterised by an apprenticeship model and therefore this pathway is not subject to accreditation or other standardised process that might confirm its quality (Helmes & Wilmoth, 2002). Geffen (2005) has also raised the additional problems of there being no minimum standard of academic performance for entry into the 2 years of supervised practice, a reliance on one supervisor across the duration, and the lack of coursework or applied research as further arguments to abandon this pathway to clinical practice. Over the past several years, the PsyBA has introduced additional assessments for this supervised practice pathway, including externally examined case reports and a final examination that is required to be passed prior to full registration, yet the internship itself remains unaccredited and unstandardised.

The PsyBA has also introduced mandatory training for supervisors under each of the training pathways in an attempt to increase the quality of supervision for provisionally registered psychologists, yet these measures do not deal with the basic limitations of the 4+2 pathway. However, there are significant impediments to mandating Master's or Doctoral level postgraduate professional training for registration as a psychologist, including governments who wish to employ a less qualified and therefore less expensive workforce, and practitioners who do not hold these qualifications and wish to retain the status quo (Helmes & Pachana, 2006). However, a National Psychology Forum in December 2015 that brought together major stakeholders in the education and training of psychologists (the PsyBA, higher education providers, the accreditation authority, professional organisation representatives, and Commonwealth and State and Territory health and education departments) sought to bring about a major shift in the pathways to professional psychology practice towards establishing streamlined, fully-accredited training for registration. A joint statement of outcomes from the chairs of the PsyBA, the Australian Psychological Accreditation Council, the Heads of Departments and Schools of Psychology Association, and the Australian Psychological Society was issued as a PsyBA communique shortly following this meeting, The major outcomes noted were a keen recognition that change to the psychology training model was needed, including a need to work towards the withdrawal of the 4+2 pathway and the recognition that Masters level training is the preferred minimum standard for professional training. It was also acknowledged that development of models of training that ensured a sustainable workforce, sustainable funding paradigms, was essential for such change to occur.

The Communique from the National Forum of December 2015 also notes delegates' interest in exploring the development of specialised areas of practice. In the case of clinical psychology, there is currently no specialist register, instead a notation on the general register of psychologists indicates that a psychologist has endorsement

in clinical psychology as an approved area of practice. An unfortunate by-product of the move to national registration was that the recognition of clinical psychology as a specialist title in some states, such as Western Australia, was lost. According to the PsyBA, endorsement of a psychologist's registration is a legal mechanism under the National Law to allow the public to identify practitioners who have an additional qualification and advanced supervised practice recognised by the Board (http://www.psychologyboard.gov.au/). Therefore, clinical psychology is generally viewed as a sub-speciality, analogous to neuropsychology, forensic or health psychology, as opposed to being viewed (as it is in other countries) as the professional base on which further clinical specialisations are built (Pachana, Sofronoff, Scott, & Helmes, 2011). The standard pathway for an area of practice endorsement is the completion of an accredited Masters degree, followed by a 2-year registrar programme (a minimum of 2 years of approved, supervised, full-time equivalent practice with a PsyBA approved supervisor), or an accredited Doctorate degree, followed by a 1-year registrar programme. Therefore, training in clinical psychology is an 8-year requirement, half of which includes training in the discipline of psychology, and half directed to the assessment, treatment and prevention of mental disorders. Continuing professional development, including a component of peer supervision, is an ongoing registration requirement for all registered psychologists.

It is worth noting that clinical psychology is not the only approved area of practice in Australia, the other eight being counselling psychology, forensic psychology, neuropsychology, organisational psychology, sport and exercise psychology, educational and developmental psychology, health psychology and community psychology, with these separate areas following the structure of the College system of the Australian Psychological Society. It has been argued that the legitimisation of the clinically-focussed areas of practice as independent specialities (specifically clinical neuropsychology, forensic and health) has led to fragmentation of the profession, with clinical psychology left with a narrower focus and a less clearly defined identity (Lancaster & Smith, 2002). Furthermore, the inclusion of traditionally clinical domains into the scope of practice of other psychology specialties, such as counselling psychology, has led to demarcation disputes and a further threat to the distinctiveness of clinical psychology (Lancaster & Smith, 2002). However, clinical psychology training programs remain dominant in Australia, with clinical psychology courses offered by 37 higher education providers across the country in 2016, in stark contrast with four offering clinical neuropsychology, two offering health psychology, two offering forensic and three offering courses in counselling psychology.

Accreditation of Clinical Psychology Training

There is a long history of accreditation of clinical psychology training programmes, stemming from State-based registration boards requiring qualifications to be accredited by the Australian Psychological Society (APS). With the introduction of the National Scheme, the accreditation function is assigned by the PsyBA to an

independent body, currently the Australian Psychology Accreditation Council (APAC). At the present time, APAC is governed by a Board of Directors nominated by its members: the PsyBA, the APS, and the Heads of Department and Schools of Psychology Association. Currently, psychology programs are independently assessed every 5 years in accordance with clearly defined standards, which are consistent across Australia. This accreditation function is being increasingly regulated, and accreditation bodies must meet AHPRA's Quality Framework for the Accreditation Function, which outlines best practice in regards to its accreditation functions, particularly in the areas of governance, independence and effective management. At the same time, the international context is becoming increasingly important and relevant to Australian psychology, and Australian psychologists are actively involved in these forums such as the International Congress on Licensure, Certification and Credentialing of Psychologists.

Training Models, Assessment, and Clinical Practice

Since the beginning of postgraduate training for clinical psychology, Australian educators have embraced the scientist-practitioner model of training and practice, following the recommendations of the celebrated conference held in Boulder Colorado in 1949. Under such a model clinical psychologists are trained as scientists as well as practitioners, courses generally are run in university departments of psychology, and the pathway to practice includes learning in the scientific discipline of psychology, as well as training in assessment and therapy, a significant research component, and a significant clinical placement experience.

The current accreditation standards for clinical psychology postgraduate training requires 1000 h of supervised practice for a Master's level qualification and 1500 h of supervised practice for a Doctoral level qualification. These requirements appear to be below those required in other countries, such as the 12-month internships required by jurisdictions in North America and New Zealand (Helmes & Pachana, 2006). At first, students undertake practice under very close supervision in clinics that are run within the higher education institution, which allows the students to be work ready when subsequently undertaking placements in hospital and community setting that are external to the higher education institution. These psychology clinics provide clinical psychology services at low cost to the public and thereby make a unique contribution to mental health service delivery across the nation.

Until very recently, all accredited postgraduate training in clinical psychology has been run by universities, and the current accreditation standards have ensured that those minority of courses run outside of universities adhere to the basic scientist-practitioner approach. However, even though a scientist-practitioner model remains a core feature of the accreditation requirements, the model is not unique to clinical psychology and cannot be regarded as defining its identity as a speciality (Lancaster & Smith, 2002). Most clinical psychologists have expertise in CBT models, with a minority of others practise in psychodynamic therapy (Meadows, Farhall, Fossey, Grigg, McDermott, & Singh, 2012). This

situation is no doubt influenced by accreditation requirements to focus on evidence-based treatments, and CBT is the predominant modality taught in the higher degree training pathway. Particularly in the case of Doctoral level training where there is a requirement for greater depth of learning, higher educational providers will teach therapy models outside of CBT such as interpersonal therapy, dialectic behaviour therapy, or psychodynamic approaches. However, probably distinctive to clinical psychology training relative to other health professions in Australia is the formulation driven approach to understanding clinical presentations and treatment planning.

Consistent with the scientist-practitioner model, the development of knowledge and skills in research remains a key component of clinical psychology training. For example, agreement on the retention of the requirement for students to undertake an independent research project within accreditation standards was a stated outcome of the National Forum held in December 2015. Many university providers offer programs of study that combine professional training with a higher research degree or PhD, with the expressed aim to foster clinical psychologists with advanced research skills. However non-university higher education providers often need additional effort to maintain a sufficient research milieu to facilitate a strong research grounding in their graduates.

The most recent shift in clinical psychology training models has resulted from the implementation of the Australian Government's new Australian Qualifications Framework (Australian Qualifications Framework Council, 2013) which now requires the equivalent of PhD-level research within a degree in order for that degree to qualify for a doctoral title. Many universities have found it increasingly difficult to fund such degrees given the significant internal training and supervision needs and the need to cap enrolments due to limited external placement capacity. Even the most basic Master-level qualifications are not self-sufficient under current funding models, and the increased requirements for research training at the Doctoral level has made these degrees, for the most part, unsustainable. It is disheartening to look back and read persuasive arguments supporting doctoral-level training in clinical psychology in Australia (e.g., McGuire, 1998; Touyz, 1995), and witness the development of such training programmes in universities across Australia across the past 10–20 years, only to now see those programmes disappear.

Pleasingly, the standards against which psychology training is accredited are undergoing a major revision, away from the current emphasis on hours of training and mandated curriculum content (Pachana et al., 2011). In line with contemporary educational practice, the standards are being revised to be more focused on competencies and graduate outcomes, and therefore will be more flexible, allowing for greater innovation in the way that higher education providers can deliver clinical psychology training. Innovations that have been a particular focus of both AHPRA and the NRAS review include the use of simulation (already used to a great extent in professional psychology training programmes) and a greater emphasis on interprofessional learning. However, despite this shift in emphasis, the standards will retain the requirement for strong oversight of supervised practice and placement programs in the field, and a focus on the important role of accreditation in public protection across the training pathways.

The Clinical Psychology Workforce

According to the most recent registration statistics (AHPRA, 2016), clinical psychologists represent 22.4% (n = 7620 of 34,026) of all registered psychologists, with the remaining holding endorsement in other areas of practice (10.9%; n = 3725), registration without an area of practice endorsement (48.3%; n = 16,446), provisional registration (13.4%; n = 4558), or non-practising registration (4.9%; n = 1677). However, in most public mental health settings today, most psychologists are clinical psychologists, with neuropsychologists also playing a role in assessment and rehabilitation (Meadows et al., 2012). Psychologists without clinical or neuropsychology qualifications tend to predominate in non-government organisations and private practice (Meadows et al., 2012). The introduction of the *Better Access* scheme, with rebates for clinical psychology services being introduced, saw increasing numbers of clinical psychologist moving away from public sector roles, and into fee-for-service private practice. Despite the significant amount of public funds being expended, *Better Access* lacks an integrated system of evaluation that could be used to examine its effectiveness (Allen & Jackson, 2011; Hickie & McGorry, 2007).

One major criticism of *Better Access* is that it has not served populations in low SES or remote locations well. Registration statistics (AHPRA, 2014) indicate that as of January 2014, 78.5% of clinical psychologists declared that their principal place of practice was within metropolitan areas and major cities, 17.7% within outer or outlying suburban and regional cities, towns and areas, with only 2.6% locating their principal place of practice as in outer regional or remote areas. Consistent with these data are findings that point to lower subsidised clinical psychology service use rates by adults living in remote areas or areas of high socioeconomic disadvantage (Meadows, Enticott, Inder, Russell, & Gurr, 2015). For example, clinical psychology consultations funded by *Better Access* were 68, 40 and 23 per 1000 population in the highest, middle and lowest advantaged quintiles, respectively. Furthermore, “increasing remoteness was consistently associated with lower activity rates” (p. 192, Meadows et al., 2015). It is telling that one of the 25 reform recommendations recently proposed by Australia’s National Mental Health Commission (2014) was to improve access to psychological services by altering eligibility and payment arrangements, to result in a fairer geographical sharing of these services.

Aboriginal and Torres Strait Islander (ATSI) mental health remains a national priority (National Mental Health Commission, 2014). There were only 23 ATSI clinical psychologists, of a total workforce of 145 ATSI psychologists, listed in the National Health Workforce Dataset for 2013 (Health Workforce Australia, 2013). An important scheme implemented by the Australian Psychological Society to redress the gaps in indigenous psychology education is the Bendi Lango initiative, established in 2006 to support students with ATSI backgrounds undertaking postgraduate psychology studies. The Australian Indigenous Psychology Education Project is another notable initiative, supported by a grant from the Federal Government’s Office of Learning and Teaching (http://www.indigenouspsyched.org.au). This project aims

to increase cultural competence in the curricular of psychology training programmes, thereby allowing psychologists to work more competently with Indigenous communities, and to increase Indigenous participation in psychology education and training. It is hoped that these and other initiatives (e.g., Behrendt, Larkin, Griew, & Kelly, 2012) will overcome the lack of Indigenous psychologists, as well as currently low cultural competence among non-indigenous psychologists.

Challenges Facing Clinical Psychology in Australia

Clinical psychologists continue to struggle with a lack of recognition and status, particularly relative to their psychiatry colleagues. Furthermore it can be argued that without a secure identity base, clinical psychology has become more vulnerable to competition from other health professions, including nursing and social work, and from other areas of psychology practice, such as counselling psychology and educational and developmental psychology (Lancaster & Smith, 2002). The trend for public health settings to employ clinical psychologists in case manager positions that do not utilise their specialist skills further undermine the identity and status of clinical psychology (Lancaster & Smith, 2002). Furthermore, the 4+2 pathway to registration as a psychologist may well have contributed to lower perceived status of psychologists among other health professionals (Patrick, 2005). There have been numerous calls for clinical psychologists to become the specialists in the provision of psychological services, and adopt the responsibilities that this leadership role suggests including greater involvement in health policy development, increased engagement with (and education of) other health professionals, and the consolidation of all clinically-focused areas of practice under the specialist title of clinical psychology (Helmes & Wilmoth, 2002; Hunt & Hyde, 2013; Lancaster & Smith, 2002). Current efforts by government that delineate the requirements for a group within a registered health profession to gain specialist title recognition under the National Law may provide a critical opportunity for such consolidation and recognition to occur.

At this point in time, placement places for clinical psychology students has reached capacity, as the numbers of students taken into training places by higher education providers have increased, and the number of senior clinical psychologists in public sector positions have decreased. AHPRA (2016) figures indicate that over 5000 psychologists have PsyBA approved status to offer supervision to provisional psychologist enrolled in higher degree programs, yet clinical psychology placement coordinators from higher education providers across the country report a significant increase in the difficulty in placing their students in suitable clinical settings. Despite the significant volume of high quality services delivered by clinical psychology students and registrars under supervision, there is little recognition of their contribution to the mental health system, evidenced for example, by recent moves by public health authorities to demand payment for placements within their services (Scott, Jenkins, & Buchanan, 2014).

Summary

In conclusion, the field of clinical psychology in Australia continues to evolve. It is only recently that texts have been published for students and professionals that are written specifically for psychological practice in the Australian context (e.g. O'Donovan, Casey, van der Veen, & Boschen, 2013; Rieger, 2014). Dissatisfaction with the long established professional body, the Australian Psychological Society, in its lack advocacy for clinical psychology as a distinct speciality has led to the establishment of a new professional organisation, the Australian Clinical Psychology Association (ACPA). ACPA's stated mission includes supporting the recognition of clinical psychology as a clearly identifiable area of expertise in mental health, and advocating for clinical psychology to government, professional and academic organisations, other health professions, and the public (Australian Clinical Psychology Association, 2010).

Clinical psychology in Australia is in a time of transformation, and there will be many opportunities to develop further as a well-recognised and valued health profession. However, there is still work to be done to cement the recognition, particularly by the larger psychology profession, that specialist training is critical for clinical practice (Macmillan, 2011). Furthermore, new and innovative models of clinical science training may be required to make certain clinical psychology does not become marginalised, and caught in conventional training models and outmoded diagnostic systems (Levenson, 2014) and certainly, a greater shift towards the acquisition and assessment of clinical competencies is vital (Pachana et al., 2011) if we are to best prepare the next generation of clinical psychologists for our constantly changing health-care environment.

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Africa

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Introduction

Contemporary Africa is a continent comprised of 54 countries, and home to more than 1.18 billion people, of which more than half (608 million) are children under the age of 19 years (World Bank, 2015). It is a continent of vast social, cultural, and economic diversity: consider that the official languages recognised by governments of the 23 countries that make up all of the North American continent are English, French, Spanish and Danish ("Official and Spoken Languages of the Countries of the Americas and the Caribbean," 2015); while South Africa alone has 11 official languages. Nigeria, the most populous African country, is comprised of more than 250 distinct ethnic groups, and 50 different indigenous languages (Bojuwoye & Mogaji, 2013).

Many historical processes and factors have contributed to the current socio-political status of the continent, not the least being colonialism (Pakenham, 1991) and the subsequent fight for independence (Ziltener & Künzler, 2013). The continent has on the one hand significant social capital, but on the other, grapples with a range of challenges and often devastating difficulties including political conflict, warfare, racial oppression, genocide, human rights abuses and atrocities, and gender violence; all of which threaten the mental health and psychological well-being of African people. Health epidemics such as HIV/AIDS and tuberculosis have taken an overwhelming toll, especially in sub-Saharan Africa, where life expectancy is the lowest at under 55 years in nine African countries, even after significant increases since 1990 (WHO, 2014). By 2005, an estimated 17 million children under the age of 17 had lost one or both parents to AIDS (UNICEF, 2006), leaving countless people vulnerable to a plethora of psychosocial problems.

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Poverty and social inequality are also strongly associated with mental illness (Lund et al., 2011). There has been significant economic growth and technological innovation in recent years, but 46 countries remain classified by the World Bank as 'low income' (LI) or 'low-middle income' (LMI) (WHO, 2008), and more than 415 million people in sub-Saharan Africa live on less than $1.25 per day (The World Bank, 2011). However, in upper-middle income countries such as South Africa, Botswana and Namibia, poverty may not necessarily be the greatest threat to mental health. Wilkinson and Pickett (2010) have argued that—more than poverty—income and social inequality are responsible for high prevalence rates of mental illness and substance abuse in rich countries. Southern Africa has the highest levels of income inequality in Africa, with a Gini co-efficient of 60.46 in Botswana, 60.97 in Namibia, and the highest Gini index in the world belongs to South Africa, at 63.38 (World Bank, 2015).

In 2010, mental and substance use disorders accounted for 19% of all years lived with a disability (YLD) in sub-Saharan Africa, making them the leading cause of disability (Charlson, Diminic, Lund, Degenhardt, & Whiteford, 2014; Whiteford et al., 2013). While epidemiological data for the continent are scarce, available studies show that between one in six (Gureje, Lasebikan, Kola, & Makanjuola, 2006) and one third (Stein, Williams, & Kessler, 2009) of people in Africa will suffer from a mental disorder at some point in their lives. However, up to 90% will not have access to treatment (WHO, 2008).

A Brief History of Psychology in Africa

Traditional indigenous African healing practices have long addressed psychological and spiritual matters (Kadri & Bennani, 2013; Kpanake & Ndoye, 2013; Mkhize, 2013; Okocha, 2013; Senyonyi & Achieng Ochieng, 2013; Stockton, Nitza, Ntinda, & Ncube, 2013). The formal scientific constructs and practices of clinical psychology have their origins in western biopsychosocial approaches to mental health and illness (Nsamenang, 2007). This approach has its origins in the early to mid-twentieth century, where almost entirely throughout Africa, academic psychology began as a subject in education and teacher training (Bojuwoye & Mogaji, 2013; Kpanake & Ndoye, 2013). Career guidance and school-based counselling have been the primary objectives of such training. With the exception of South Africa, clinical psychology programs are recent additions to relatively young psychology departments (Cooper & Nicholas, 2012; Moodley, Gielen, & Wu, 2013; Stevens & Wedding, 2004).

As a discipline, clinical psychology is somewhat unique in that it straddles both the health sciences and the arts or humanities and is informed by (and informs) medicine, philosophy, sociology, and anthropology. As a result, it is arguably—perhaps more than any other discipline in the sciences—profoundly political. Its history and presence in Africa are controversial, with critical theorists asserting that psychology is yet another means by which colonial powers have sought to displace and subvert indigenous knowledge, asserting superiority of practice and thought (Holdstock, 2002; Mkhize, 2013); and that its continued existence is a perpetuation of social oppression (Howitt & Owusu-Bempah, 1994). For example, psychology has been

used as an oppressive tool to justify slavery in Africa; to show that African children have sub-normal intelligence; and to argue for racial segregation by using psychometric tests to scientifically 'prove' the inferiority of black people (Long, 2013, 2014; Nsamenang, 2007; Oyebode, 2006). Notably, the infamous architect of the apartheid system in South Africa, Hendrik Verwoerd, was a professor of Applied Psychology at the University of Stellenbosch, in Cape Town (Cooper & Nicholas, 2012). However, more positive applications may be seen in the contributions of Joseph Wolpe and Arnold Lazarus, considered to be pioneers of behaviour therapy and integrative methods, which provided a base for subsequent evidence-based psychotherapies (Cooper & Nicholas, 2012; Stein, 2012). (For more comprehensive accounts of psychology's history in Africa, see Cooper, 2014; Nsamenang, 1995; Moodley et al., 2013; Stevens & Wedding, 2004). More recently, Africa is emerging as a leader in the global mental health movement and in efforts to develop equitable mental health care, with studies such as AFFIRM (Lund et al., 2014), PRIME (Lund et al., 2012), and Project EMERALD (Marais & Petersen, 2015), which are multi-country research projects that are breaking new ground in intervention development and delivery.

In the chapter ahead, various aspects of the discipline of clinical psychology within the African context will be presented, beginning with an overview of the current state of mental health in Africa. The training and regulation of clinical psychologists around Africa will then be presented, followed by a consideration of matters pertaining to diagnostics. Finally, the psychotherapies and interventions most widely used will be discussed, along with a brief exposition of the implications of the global mental health movement for clinical psychology on this continent. Since a comprehensive consideration of this topic would require several volumes, this chapter can only represent a limited view of the subject. The aim of this chapter is to provide a very broad overview of clinical psychology in Africa, acknowledging that our experience and perspective is overwhelmingly South African.

Africa's Current Mental Health Status

Matters of Epidemiology

Not surprisingly, the majority of available studies investigating the epidemiology of mental disorders have been conducted in countries with high income (HI) economies. A recent systematic review and meta-analysis of all studies that utilized a national or regional general population sample between 1980 and 2015 identified 174 studies overall, 106 surveys from HI settings and 68 surveys within LMI settings. Results indicated that approximately one in five respondents (18%) met criteria for a common mental disorder during the 12-months preceding assessment and 29% were identified as having experienced a common mental disorder during their lifetime (Steel et al., 2014). However, it appears that the availability of nationally representative data is increasing in a number of low-income countries, with very limited data available from Africa (Baxter, Patton, Scott, Degenhardt, & Whiteford,

2013). Given this lack of data many assumptions about the prevalence of mental disorders in Africa are made from other populations, despite varying cultural, environmental and genetic factors (Baxter et al., 2013).

In order to address this research gap, the World Mental Health Survey (WMHS) collaboration has provided an infrastructure for researchers in LMI countries to conduct population surveys (Kessler & Ustun, 2008). A total of 28 LMI countries have conducted these surveys, two from Africa. First, in the Yoruba-speaking part of Nigeria, the lifetime prevalence for any disorder was 12.1% and 5.8% had a 12-month disorder (Gureje et al., 2006). Interestingly, anxiety disorders were the most commonly identified disorder, yet none of the Nigerians interviewed reported symptoms of generalized anxiety or post-traumatic stress disorder. These prevalence rates are of the lowest reported amongst the countries participating in the World Mental Health Surveys (Gureje et al., 2006). Although the reasons underlying the low estimated prevalence remains unclear, it is possible that this is due to underreporting, or the social and cultural factors specific to Nigeria and other African societies. A different pattern emerged in South Africa, where results from the South African Stress and Health Study (SASH) (Stein, Williams, & Kessler, 2009), the first nationally representative study of psychiatric morbidity in South Africa, showed that the lifetime prevalence for any disorder was 30.3%, including anxiety disorders (15.8%), substance use disorders (13.3%) and mood disorders (9.8%). The 12 month prevalence of mental disorders was 16% (8.1% anxiety, 5.8 substance use and 4.5 mood disorders) (Herman et al., 2009; Stein et al., 2009).

Although these nationally representative studies provide valuable insight into the prevalence of CMDs in South Africa and Nigeria specifically, much additional work is needed to gain an understanding of the epidemiology of mental disorders in other African settings. One possible way to address this gap is to include mental health data in more general health surveys, should obtaining funding for mental health surveys specifically, be a barrier.

Mental Health Policies

According to the WHO's *Mental Health Atlas* (WHO, 2011), only 19 of the 46 African countries that are WHO member states have dedicated mental health policies that are state endorsed, with 80% of those countries also making reference to mental health in their general health policies. Two thirds of African countries have mental health plans in place, and almost 45% have legislation in place that deals specifically with mental health issues (compared with Europe's 80%). Calls to prioritise mental health have come from a wide range of organisations and sources, and the WHO's efforts to guide governments via initiatives such as the *mental health Global Action Programme* (mhGAP) and the *Mental Health Policy and Service Guidance Package* (WHO, 2003) have been useful: 56% of those African countries with mental health policies either revised or implemented their policies for the first time since 2005 (WHO, 2011). However, this figure represents the lowest level of policy development

of all the WHO regions and may represent a challenge to the objectives of the WHO's *Mental Health Action Plan 2013–2020* (2013), which include strengthening effective governance and leadership for mental health; and providing comprehensive, integrated and responsive mental health services in community-based settings (WHO, 2013). Saxena, Thornicroft, Knapp, and Whiteford (2007) suggest that the stigmas associated with mental illness and the scarcity of research about cost-effective interventions in local settings might pose as hindrances to mental health policy development in the region.

Mental Health Resources

As evidenced above, while some ground has been made in underscoring its centrality to health, mental health largely remains non-prioritised and under-funded across African states (Monteiro, 2015). Where expenditure is concerned, Gross National Income (GNI) per capita is closely correlated with mental health expenditure per capita, such that wealthier countries allocate a greater proportion of their health budget to mental health than LMI countries do (Saxena et al., 2007). In Africa, the median percentage of health budget that is allocated to mental health is 0.62, while Europe's is almost tenfold that amount (WHO, 2011). It is noteworthy that Africa has the highest median expenditure on mental hospitals (as a percentage of all mental health expenditure), possibly reflecting a slower rate of decentralisation and less developed community-based services (Saxena et al., 2007).

In terms of human resources, the WHO's *Mental Health Atlas* (2011) counts 1.7 human resources working in the mental health care sector per 100,000 people in Africa, with 0.05 psychiatrists and 0.04 psychologists for every 100,000 people (compared to Europe's 8.59 psychiatrists and 2.58 psychologists per 100,000 people). Only 23% of African countries provide training on mental health to primary health care (PHC) doctors. However, Africa has the highest percentage of countries with an official policy or legislation that enables PHC nurses to diagnose and treat mental illness; a trend that is more evident in low-income countries than in countries with high-income economies and is perhaps indicative of the shortages of mental health specialists. With more nurses working in mental health than any other professionals (0.61 per 100,000), it is also the reason that innovations in mental health services are looking increasingly towards interventions delivered by this resource (WHO, 2011).

Training Programs and Regulatory Organisations

In the broadest terms, the practice of clinical psychology is comprised of assessment, diagnosis, and treatment or rehabilitation. The latter might range from providing psychotherapeutic intervention, to simply making recommendations as to the best possible treatment approaches, to referring to another appropriate professional or service. It would

be reasonable to assume that clinical psychology training across contexts would seek to provide trainees with a sound knowledge of how to provide appropriate and relevant services in all three areas. However, given the complexity of Africa's particular (and diverse) mental health challenges, determining the appropriate content and model of training is not always as straightforward. Graduate training programmes in clinical psychology can be expensive; limited resources—including access to funding—are among the challenges faced by academic departments that provide such training, especially in countries where the discipline is considered low-status. Where state funding is concerned, psychiatric illnesses are often regarded as a low priority in the face of other life-threatening epidemics such as HIV and AIDS, TB, malaria and recently, Ebola.

Only ten African countries have professional associations of psychologists, namely, Botswana, Egypt, Ethiopia, Kenya, Morocco, Namibia, Nigeria, South Africa, Sudan, and Uganda (Reynolds Welfel & Kacar Khamush, 2012). Zimbabwe, Namibia and South Africa are the only three countries that have state regulation for the practice of professional psychology (Namibia Ministry of Health and Social Services, 2009; Reynolds Welfel & Kacar Khamush, 2012). Typically, higher education institutions provide training in psychology under the auspices of their education departments or teacher training (Bojuwoye, 2006). While a wide variety of counselling courses are offered in academic and private spheres (Hohenshil, Amundson, & Niles, 2013; Moodley, Gielen, & Wu, 2013), academic institutions that offer applied psychology degrees at postgraduate level (usually educational or counselling psychology degrees) are few and far between Programmes in clinical psychology are even less common. Amongst those African countries that do offer graduate programmes in clinical psychology, there is often limited information available about course content and a lack of clarity concerning the minimum requirements to qualify for this specialist role. It is of interest to note that only 28% of applied psychology programmes in African countries include clinical supervision as a component of their training (WHO, 2010). This is probably primarily due to the severe limitation in human resources in mental health; as well as the lack of specialists to provide on-site training (Hall, Kasujja, & Oakes, 2015).

North Africa

Psychotherapy has a long history in North Africa. However, as is seen elsewhere across the region, in Egypt, the term 'psychology' is often used interchangeably to denote psychiatric, psychotherapeutic and counselling practices, which has led to some confusion as to the differentiation between roles of each professional (Amer, 2013). Academics frequently lament the fragmented identity of psychology as a discipline in Egypt (Amer, 2013; Mikhemar, 2013; Mohamed, 2012). There are several universities that offer postgraduate diplomas in applied psychology and undergraduate degrees in psychology, but there are no specific academic requirements for the practice of clinical psychology (Mikhemar, 2013). Licensure as 'psychotherapist' is extended to those who have completed training in psychiatry or neurology; have specialized

training in psychotherapy, or a psychology postgraduate degree; and, have at least 2 years of clinical experience at an accredited institution (Amer, 2013). In contrast, neighbouring Libya's training of psychologists is limited to a bachelor's level education, typically focused on education, but there is currently no formal training in applied or clinical psychology and no professional regulatory body (Weissbecker, 2011). Similarly, while Sudan has a professional association for psychologists (Reynolds Welfel & Kacar Khamush, 2012), psychology is considered a low-status discipline and as such, education in the field is limited and no licensing or regulatory functions exist (Adil, Abdallah, & Badri, 2010). Moroccan universities offer 2-year postgraduate diplomas (master's-level equivalent) in psychology, but no standardized licensure and certification process yet exists (Kadri & Bennani, 2013). Algerian psychologists fought a long battle to find professional protection and recognition under state law, and recently established a professional association, under which several universities are accredited to offer postgraduate training in clinical psychology (Kacha, 2012).

West Africa

Nigeria, the most populous African country, has 28 universities with accredited psychology departments that offer graduate and postgraduate degrees in psychology, many with training in clinical psychology up to master's and PhD level (Bojuwoye & Mogaji, 2013; Mefoh, 2014). According to Oppong Asante and Oppong (2012) the University of Ghana is the only one of four universities in Ghana to offer postgraduate training in clinical psychology, including a Master of Philosophy and PhD. With no licensing body, the only legal requirement to assume the specialist title of 'Psychologist' is a postgraduate degree in psychology (Oppong Asante & Oppong, 2012). Kpanake and Ndoye (2013) report that all francophone West African countries (including Benin, Burkina Faso, Senegal, Niger, and Togo) have academic programmes in psychology, but only Togo's Université de Lomé has a 2-year postgraduate master's degree training programme in clinical psychology, which includes coursework and an internship. Burkina Faso's Université de Ouagadougou offers a 4-year degree programme (within the Philosophy Department) that focuses on clinical psychology in the second 2 years and also includes an internship (Kpanake & Ndoye, 2013). Of these, none are state regulated and only Nigeria has a professional association for psychologists (Reynolds Welfel & Kacar Khamush, 2012).

East Africa

Like much of Africa, formal psychology training in East African universities, such as those in Zambia, Zimbabwe, Kenya and Malawi, typically falls under education and teacher training (Bojuwoye, 2006; Chamvu, Jere-Folotiya, & Kalima, 2006; Koinange, 2004). Recently, the University of Gondar launched the first Master of

Arts in clinical psychology in Ethiopia, a 2-year programme that aims to produce graduates skilled in science, theory and practice (Wondie, 2014). Similarly, Makarere University in Uganda also offers a Master's in clinical psychology of 2 years' duration (Hall et al., 2014, 2015) and a professional association exists but membership is open to anyone with a bachelor's level education in psychology (Hall et al., 2014). Zimbabwe's universities offer degrees in psychology, up to master's degree level but there is no clear differentiation between various sub-disciplines (no specific category for clinical psychologists exists), which is echoed in the broad nature of the national regulatory body's licensing category for psychologists (AHPZ, 2015). In Kenya, there are no clinical psychology training programmes (Koinange, 2004; Okech & Kimemia, 2012) and with only three clinical psychologists (none of whom work in public service), no regulatory body (Ndetei & Gatonga, 2011). Universities in countries such as Tanzania (Hassan et al., 2009) and Zambia (Mayeya et al., 2004) do not currently house dedicated psychology departments; nor do they have regulatory or licensing bodies.

Central Africa

In Central African countries, academic and applied psychology training programmes are also scarce. The Democratic Republic of the Congo (DRC) has 600 universities and higher education institutions of which only three have Psychology departments and all fall under Social and Educational Psychology; none offer clinical psychology programmes (Bazibuhe, 2013). Similarly, as a discipline of low academic status in Cameroon, the few institutions that do offer applied psychology programmes are in the field of Educational Psychology, guidance and counselling (Nsamenang, 2013; Tchombe & Kassea, 2006). Programmes in the Congo, the Central African Republic (CAR), and Chad are almost entirely absent.

Southern Africa

This is in stark contrast with the neighbouring region of Southern Africa, where South Africa currently has 14 universities that are accredited by the national regulating body to provide training in clinical psychology (HPCSA, 2015). In this country, a minimum of a masters-level degree in clinical psychology is required, which is comprised of a year of course work, the successful completion of a research dissertation, and a minimum of 1 year's internship training at an accredited institution (usually a tertiary-level psychiatric hospital) (HPCSA, 2009). In order to register as an 'Independent Practitioner', newly qualified graduates are also required to complete 1 year of public or community service at sites identified by the National Department of Health as those most under-resourced. Likewise, the University of Namibia offers a similar masters-level training in clinical psychology (University of

Nambia, 2015). Botswana offers an undergraduate degree in applied psychology, but does not offer postgraduate training in clinical psychology, nor is the practice of psychology legally regulated (Stockton et al., 2013).

Psychopathology, Culture, and Nosology

Notions of what constitutes healthy or unhealthy human behaviour are at least in part determined by the belief and value systems espoused by the societies in which they occur (Amuyunzu-Nyamongo, 2013; Nsamenang, 2006). For example, many lay people assume that auditory verbal hallucinations are a sign of serious mental illness; a symptom of psychosis; and, evidence of a psychiatric illness such as schizophrenia or bipolar mood disorder and of course, this is one plausible explanation. However, perceptual experiences that are not shared by others are not always signs of psychopathology (for example, the phenomena of hypnagogic/hypnopompic hallucinations) (McCarthy-Jones, 2012). Furthermore, in some cultures psychotic phenomena may be understood as having altogether different meanings, such as the result of being cursed or possessed by evil spirits (Bhikha, Farooq, Chaudhry, & Husain, 2012; Swartz, 1998). For example, *amafufunyana* has been described by South African mental health scholars as a complex condition with important social functions, that might include (but is not limited to) signs and symptoms that resemble those of schizophrenia (Niehaus et al., 2004; Swartz, 1998), and is believed to be the manifestation of spirit possession involving sorcery (Lund & Swartz, 1998). As corollary to this, a non-pathological perspective of hearing voices might include the supernatural ability to receive spiritual knowledge from a higher power or from one's ancestors (Bhikha et al., 2012), as seen in *ukuthwasa*, another example from South Africa, which refers to a range of experiences that are believed to be the result of a calling from the ancestors to become a healer (Swartz, 1998). Neither *amafufunyana* nor *ukuthwasa* have fixed definitions or sets of criteria, but are thought to provide explanations for a range of psychological experiences and problems, including epilepsy (Keikelame & Swartz, 2015; Swartz, 1998).

While there are many approaches to psychiatric nosology (Avasthi, Sarkar, & Grover, 2014), the American Psychiatric Association's Diagnostic and Statistical Manual (DSM-5), along with Chapter V of the WHO's International Classification of Diseases (currently, the ICD-10) are the two most widely used psychiatric taxonomic systems in the world (Reed, Mendonça Correia, Esparza, Saxena, & Maj, 2011). Reed et al.'s (2015) global survey of 4887 psychiatrists' attitudes toward the classification of mental disorders found that 83% always/often use a formal classification system, with 64% most often using the ICD-10. Of the five African countries that were included in the survey, more South African and Nigerian psychiatrists reported often/always using formal classification systems (95% and 94% respectively), however, only 20% of South African psychiatrists reported most often using the ICD-10, compared to 83% of Nigerian psychiatrists. None of the 77% of Kenyan psychiatrists who reported using classification systems made use of the

ICD-10. In North Africa, 55% of Egyptian psychiatrists reported a preference for the ICD-10 over Morocco's 22% (Reed et al., 2015).

In a similar study of psychologists' attitudes towards the diagnostic classification of mental disorders, Evans et al. (2013) found that more than 65% of 1817 psychologists from 23 countries around the world often/always use a classification system. Of the 106 psychologists from four African countries, almost 70% reported often/always using a diagnostic classification system, with 55% (75.5% weighted) using the DSM-IV most often and 37%, the ICD-10 (38.3% weighted). Where South African's preference was only marginally for the DSM-IV (49.4% against 45.6% for the ICD-10), Uganda's psychologists appear to favor the DSM-IV substantially more (69.2%) than the ICD-10 (7.7%). However, while most South African universities and psychiatric hospitals train students diagnose with the DSM, medical insurance companies require the use of ICD-10 diagnostic codes, possibly explaining the low differentiation in preference for South African psychologists. Importantly, more than one third of all participants felt that the diagnostic criteria of the ICD-10 and the DSM-IV were difficult to apply across cultures; while those from Africa, the Eastern Mediterranean, and Latin America more often agreed that the Euro-American bias of both systems was problematic (Evans et al., 2013).

A long-standing tension exists between proponents of the biomedical model of psychopathology and those who support anthropological notions of mental illness (Stein, 1993; Town & Wiley, 2006); a debate that has been highly relevant to African psychology. A biomedical approach has emphasized growing evidence of genetic and biopsychological mechanisms underlying many psychiatric disorders, although few validated biomarkers have been identified (Insel & Wang, 2010; Nesse & Stein, 2012). An anthropological perspective has emphasized that the ways in which a disorder manifests is determined by sociocultural and environmental factors (Bentall, 2014; Canino & Alegría, 2008; Patel, 2014; Swartz, 1998). When it comes to help-seeking, the personal and cultural meaning that is made of the phenomenon and the experience thereof (including etiology) will directly inform the kind of help that is sought, if any at all. Referring to common mental disorders such as depression or substance abuse disorders, Patel (2014) notes a 'credibility gap', explaining:

> … the vast majority of people who have a diagnosis of depression or harmful drinking, based on a psychiatric interview or clinical diagnosis, do not understand their problem as a distinct health condition with a biomedical causation; instead, they utilise culturally meaningful labels and causal explanations for their distress as being inextricably linked to their personal lives. (Patel, 2014, p. 17)

The subjective meanings that are attributed to the experience of mental illness must be central to psychologists' conceptualisation of the most appropriate and helpful ways to intervene at both the community and individual levels. However, the lack of resources and the very real and growing treatment gap necessitates innovative thinking about equitable and cost-effective approaches to psychological treatments.

Psychotherapy and Interventions in the Context of Global Mental Health

Patel's (2014) argument becomes all the more pertinent when considering that many African people turn to traditional healers to treat their health and psychological problems (Sorsdahl et al., 2009; WHO, 2002). This shows that the ways in which people make sense of their symptoms, otherwise known as explanatory models of mental illness, may determine the kind of help that is sought and have a direct bearing on the uptake of mental health services. Furthermore, according to Amuyunzu-Nyamongo (2013) and Fournier (2011), the preference for traditional healers (including religious healers) is due to the widespread stigma and taboo associated with mental illness and because "mentally ill people are usually shown [more] empathy from the community if they visit a traditional healer than if they choose to seek help from a mental hospital" (Amuyunzu-Nyamongo, 2013, p. 62). This underscores the necessity of psychological treatments and therapies that are compatible with the worldviews of the communities that they seek to serve (for more on this issue, see for example, Campbell-Hall et al., 2010; Holdstock, 2000; Nwoye, 2015; Sher & Long, 2012; Sorsdahl et al., 2009).

Psychotherapeutic Approaches

All psychological treatments or therapies are grounded in theories that hypothesize about the mechanisms and dynamics that cause the psychological problems that those treatments seek to remedy. A psychological theory seeks to explain the etiology of a problem, while the corresponding treatment uses that theory's explanation to forge a way back to health. The implication is that theories are based on assumptions about what it means to be a mentally healthy person; a way of being and relating, and of experiencing oneself in the world that is in keeping with particular notions of well-being and health. While this may seem logical, it is important to bear in mind that definitions of mental health and well-being often vary across cultures. For example, some psychoanalytically-derived theories regard the processes of separation and individuation as central to psychological maturity and functional adulthood. As such, relational problems (like those often experienced by people with Borderline Personality Disorder) might broadly be explained as deeply rooted and unconscious ambivalence towards those developmental events; as separation comes to represent the threat of rejection; and individuation—abandonment and loneliness (Edward, Ruskin, & Turrini, 1991). The objective of psychotherapy might be to uncover the repressed injuries that impeded the ego's ability to develop appropriate defences to tolerate the losses inherent to individuation, and then to develop healthier defence mechanisms. The ultimate goal is clear: separation and individuation. However, many traditional African cultures espouse a collectivist worldview, where the idea of independence from the family of origin, children, and

community is anathema. For example, in South Africa "Ubuntu" is a well-known Nguni term that refers to the idea of a communal humanity; the principle of community above self; and which translates as "People are people through other people" (Nyamburu Machiri, 2009). The concept of individuation might well be seen as being at odds with Ubuntu, and a therapy that has separation and individuation as its primary therapeutic goals might be inappropriate, at best. Furthermore, we now know that psychological development (both healthy and unhealthy) is profoundly influenced by our broader socio-cultural environments. An awareness of this is central to considering the application of these theories to contexts in which they did not originate; where particular ideas of healthy behaviour and being in the world are at odds (or even simply a poor fit) with the worldview or circumstances of the people they seek to understand and help.

Due to the discipline's western roots, and partly as a result of globalisation, the psychological theories most frequently taught in clinical psychology programs are generally in keeping with those taught at American and European institutions (see Hohenshil, Amundson, & Niles, 2013; Moodley, Gielen, & Wu, 2013; Stevens & Wedding, 2004). These include psychoanalysis and its psychodynamic derivatives (for example, therapies informed by the theories of Klein, Kohut, Fairbairn, Bowlby, and more recently, theories of intersubjectivity); Rogerian person-centred therapy; behavioural and cognitive therapies and their derivatives (such as cognitive behavioural therapy, rational emotive behaviour therapy, solution-focused therapy, and problem-solving therapy); systemic theories such as family systems theory, are also widely taught in programs and applied in practice (Amer, 2013; Bojuwoye & Mogaji, 2013; Kadri & Bennani, 2013; Kpanake & Ndoye, 2013; Lazarus et al., 2006; Weissbecker, 2011). Therapies based on systems theory are frequently cited by those western therapies that are amongst the most compatible with many Africa cultures' strong orientation towards family, and values that prioritize collectivism and community (Kpanake & Ndoye, 2013).

Community psychology also has a strong presence in African training programs (Lazarus et al., 2006). Its context-driven conceptualisation of psychological problems as evidence of social and environmental disequilibrium resonated powerfully with African scholars who were dissatisfied with Eurocentric individualistic models that largely disregard social and political factors (Ratele et al., 2004). Furthermore, community psychology prioritizes prevention over cure and seeks to develop interventions that are grounded in the needs of the community, as determined by the community members themselves (Duncan, Bowman, Naidoo, Pillay, & Roos, 2007). Also, given the centrality of indigenous healing as well as spiritual and religious beliefs to conceptions of mental illness, academics have repeatedly called for the development of African-centred therapies (Edwards, 2011; Nsamenang, 2006). Community psychology, as a context-driven philosophy of care, actively seeks to engage and include indigenous knowledge and practice.

The indigenisation of western psychotherapy models has been another major point of discussion in African psychology (Mkhize, 2013; Sher & Long, 2012). Where indigenous therapies are those that originate in a particular cultural setting (for example, psychoanalysis is indigenous to European culture); the indigenisation

of therapies refers to the adaptation of therapies developed elsewhere, for application to other settings (Mkhize, 2013). In Africa, this has primarily meant adapting western therapies, such as CBT, to local settings. These adaptations are particularly relevant and applicable to the global mental health (GMH) movement, discussed next.

Global Mental Health and the Call for New Professional Roles

The GMH movement is driven by the imperative to equitable mental health across all income contexts, from low to high (Patel, 2012). It aims to develop and implement effective and accessible interventions so as to reduce the treatment gap in mental health and reduce the widespread disability related to the prevalence of mental illness. The movement's advocacy for viable, quality approaches to mental health treatment has generated substantial support for task shifting; an approach that may translate into more cost-effective ways of delivering health services to more people, so ultimately providing feasible strategies for reducing the large mental health treatment gap (Rebello, Marques, Gureje, & Pike, 2014). Endorsed by the WHO, task shifting (also known as task sharing) is defined as "… involv[ing] the rational redistribution of tasks among health workforce teams. Specific tasks are moved, where appropriate, from highly qualified health workers to health workers with shorter training and fewer qualifications in order to make more efficient use of the available human resources for health" (WHO, 2008, p. 2). Where mental health is concerned, this means that less complex diagnostic cases can be carried by non-specialist health workers (NSHW) so as to free up specialist human resources (such as clinical psychologists and psychiatrists) to deal with those cases that require greater expertise and management (Kakuma et al., 2011). However, the WHO's advocacy for the integration of mental health in to primary health care means that NHSWs (such as nurses, community health workers, and lay counsellors) are placed at the forefront of mental healthcare delivery (WHO, 2007), necessitating a reconsideration of the roles that specialists might play. In addition to being clinicians; clinical psychologists' duties might be expanded to included intervention design, human resource management, training and clinical supervision of NHSWs (Patel, 2009); roles that will almost certainly change the face of the discipline's practice in public health settings, not just at primary care level. Furthermore, while task-shifting treatments to NHSWs offer a cost-effective solution to under-resourced mental health services, it cannot be thought of as a substitute for the skills of specialists like clinical psychologists.

In response to the growing treatment gap and the GMH movement's endorsement of equitable mental health services, several Southern African countries, including Botswana, Namibia and South Africa, introduced a mid-level category of mental health professional in the form of the 'registered' or 'psychological counsellor'. This qualification includes a 4-year Honours-equivalent degree with a curriculum that is psychology-focused and includes a 6 month practicum (Abel & Louw, 2009; University of Botswana, 2015; University of Namibia, 2015). This is an added tier

of mental health expertise that might prevent specialists from becoming encumbered by administrative and human resource management work. The potential of this category within an integrated primary health care service has not yet been well explored.

GMH is not simply concerned with the accessibility of mental health services, but also with the promotion of equitable services in terms of standards and quality of care. To this end, the utilisation of treatments and interventions that have been empirically tested and shown to be effective is central to GMH's agenda (Vikram Patel, 2012). According to Kazdin (2014), 320 evidence-based practices (EBP) for mental health and substance abuse disorders have been identified, including interventions for people across the lifespan. However, he also notes that EBPs are not invariably more effective than treatment as usual (although the standardization and parameters for treatment as usual in psychological care are rarely clear, making it potentially harmful), and concerns have been raised regarding some of the methodologies employed to generate evidence for such treatments (Kazdin, 2014). Furthermore, much of the evidence for the efficacy of therapies such CBT has been generated in western or high-income settings, and the empirical support for their adaptability and application to African or low-income contexts is still relatively thin, sometimes with mixed results (Monteiro, 2015; Spedding, Stein, & Sorsdahl, 2015). This has served as a significant source of criticism for the GMH movement (Kirmayer & Pedersen, 2014; Swartz, Kilian, Twesigye, Attah, & Chiliza, 2014) and is an area that requires a great deal more attention if treatments are to be successfully and effectively task-shifted to NHSWs.

Conclusion

Africa is a vastly diverse continent, where the history of psychology is complex and contentious. Contemporary clinical psychology has found traction to varying degrees in countries across the continent and has largely developed in response to the many challenges faced by African countries. However, for a variety of reasons, mental health is still largely non-prioritized (Tomlinson & Lund, 2012) in most African countries and the substantial treatment gap is growing. The global mental health movement's has advocated for the development of innovative strategies to make equitable mental health services more accessible to those who need them; strategies that are evidence-based and robust enough to be task-shifted to less qualified human resources.

Where these developments are concerned, the future of clinical psychology in Africa faces several challenges. First, evidence for the adaptation of interventions to local contexts needs further development. The call for evidence-based practice is an important one to heed, especially in view of task shifting mental health care to NHSWs: ensuring that psychotherapies and interventions are supported by sound research is essential. However, this does not negate the need for practice-based evidence: the understanding of what makes an intervention work within a given context (Wand, White, & Patching, 2010). Furthermore, common elements treatment

approaches (Murray et al., 2014) that are grounded in values-based practice (Fulford, Peile, & Carroll, 2012), might facilitate more meaningful adaptations of therapies to local contexts and require further investigation. Second, where training is concerned, more attention needs to be given to the lack of supervision in clinical internships; and training programs for clinical psychologists need to address the potential role changes for the profession: emphasising program and intervention development, and supervision and training of NHSWs (which arguably requires a different set of skills to those used to supervise other clinical psychologists, who have the same or similar training in mental health) (Pillay, Ahmed, & Bawa, 2013). Third, if the global mental health movement is to be successful in achieving its agenda, the potential of mid-level specialists such as registered counsellors, requires thorough investigation. The expertise gap between community health workers and specialists is simply too wide. The role that a cadre of professional counsellors might play, and the contributions they might make to an integrated mental health service requires thorough exploration. Finally, the temptation to see task-shifted approaches as the panacea to the pressure of a growing treatment gap must be resisted. The specialist skills of clinical psychologists are essential, especially in contexts where innovative approaches are being developed and tested. Task shifting is one cost-effective solution. Government prioritization of mental health as an issue with profound implications for health, social and economic development has to be another. To the advocacy of increasing mental health resources in Africa and around the world, the discipline of clinical psychology must lend its voice.

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Middle East

Asala Halaj and Jonathan D. Huppert

Introduction

Psychology began to arrive in the Middle East in the early twentieth century. However, some countries advanced more quickly and have developed professional psychology more than others. For example, there are large differences among the various countries in the Middle East in the numbers of psychologists. This chapter provides an overview and description of the current state of clinical psychology in the Middle East. The Middle East is a region that runs from Egypt in the southwest to Turkey in the northwest to Iran in the northeast and Oman in the southeast.[1] Descriptions are mostly based on an informal survey of professionals which included communications with professionals in each country via email and Skype; we assume that the clinical psychologists surveyed here reflect general perspectives about the field in each country, but we could not verify the information obtained. For each country, we describe (where available): (1) the field's historical development with the country; (2) clinical psychologists' training, academic and professional requirements, and employment settings; (3) the numbers of psychologists employed in the mental health sector (according to a survey conducted by the World Health Organization in 2014 (World Health Organization, Substance Use of Mental Health, 2014) and according to our informal survey results); dominant theoretical orientations used in the country, and religious and cultural context in each country. Given

[1] The countries include: Bahrain, Egypt, Iraq, Iran, Israel, Jordan, Kuwait, Lebanon, Oman, Qatar, Saudi Arabia, Syria, Turkey, United Arab Emirates, and Yemen. We also included the Palestinian territories which are self-administered and have their own health system. There are disagreements about whether Cyprus is included in the countries of the Middle East, but given that they are mainly Greek-speaking and part of the European Union, we did not include them in our review.

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the similarities in responses that we received about stigma and cultural/religious context of dealing with clinical psychology and mental health issues in Arab-speaking countries and Iran (all of whom are majority Muslim countries), we start by reporting a review of these issues and follow with a review of the specifics of clinical psychology in each country. Finally, this chapter discusses the obstacles and challenges that face the discipline and may potentially affect the future of clinical psychology in the Middle East.

Culture, Religion, and Mental Health

Cultural and religious beliefs influence the manifestation and treatment of mental health in most countries in the Middle East. As a result of these beliefs, there is a lack of awareness regarding the profession of clinical psychology and what it can offer, and a negative attitude towards seeking professional help instead of seeking help via religious clergy, friends, or family members. Social stigma regarding mental illness and its treatment is common in these countries. This stigma likely exacerbates negative attitudes and reactions towards individuals with psychological disorders in the Arab communities and affects the health and well-being of these individuals. For instance, individuals with mental illness are often socially rejected, experience more divorce, and have a tendency to not get married (Dalky, 2012). Often, this stigma prevents individuals from seeking treatment (if they do decide to obtain help, they do so secretly) because of the belief that undergoing treatment for mental illness is shameful or fear that the individual seeking treatment may be perceived as “going crazy” (Almazeedi & Alsuwaidan, 2014). However, in some countries, such as in Iran, mental illness has recently become less of a stigma because of the increasing belief that life experiences (traumatic events and life stressors) can cause mental disorders.

Besides stigma, other cultural and social factors impact the perception of mental health in Arab countries. For instance, in Kuwait, concerns about breaches of confidentiality, the Kuwaiti people’s perception that mental illness is shameful, and the way people tend to spread rumors about mentally ill individuals in Kuwaiti society all seem to negatively impact the experiences of those individuals who seek treatment (Scull, Khullar, Al-Awadhi, & Erheim, 2014).

Similar to social factors, religion appears to play an important role in Muslims lives. Mental disorders may not be accepted among individuals due to the belief that mental health issues result from religious (Okasha, Karam, & Okasha, 2012) and traditional sources such as spiritual forces (*Jinn*), contemptuous envy (*Hassad*), and sorcery (*Sihr*). For example, the Arabic term *waswas* is used in both psychological and religious contexts in reference to obsessions. Waswas refers to “insinuating whispers” of the shaytan (Devil). According to the Islam, the devil tries to control the believer and make the individual doubt the existence of Allah (God), as well as other basic religious beliefs in religion. Thus, there is a form of intrusive religious thoughts that are described in Islam, and the typical adherent will seek treatment or

advice by clergy. This phenomenon is close to the intrusive, heretical thoughts that can characterize scrupulosity, a religious form of obsessive compulsive disorder (OCD).

There are suggestions in the literature that Islamic practice and rituals may interfere with therapy, and it is unacceptable to replace the time of prayers with any other activity such as psychotherapy. For example, cleaning rituals are practiced by conservative religious Muslims for the purpose of praying (Baidas, 2012), and this may elevate the likelihood of OCD manifesting in such a way. This religious outlook could affect therapeutic alliances and compliance and, in turn, affect clients negatively (Alqahtani & Altamimi, 2016; Miller & Thoresen, 2003). Other Islamic rules, such as not allowing a male stranger in the same room as a woman, could decrease acceptance of clinical psychology given that most psychologists are women. Although allowing another mental health professional to be present usually solves this problem, confidentiality could then become an issue (Alqahtani & Altamimi, 2016; El-Islam, 2008). There have been suggestions in the literature that cultural practices such as wearing a hijab could limit the therapy outcome and affect the therapeutic alliance negatively. For example, wearing hijab and covering the face could prevent the therapist from understanding facial expressions and, therefore, the client (Alqahtani & Altamimi, 2016; Inhorn & Serour, 2011). While there have been recent attempts to integrate religion and psychology, more collaboration is needed between mental health providers and religious leaders to emphasize the important role of psychologists (Ahmed, 2004; Amer, 2013). On the other hand, religious thoughts may have a positive impact on psychological treatment as it can facilitate the development of coping skills during treatment and even attendance. For example, religious counseling is associated with psychotherapy treatment in the United Arab Emirates (UAE). In addition, using CBT techniques in therapy could be beneficial for Muslim clients because these approaches combine religious invocation and traditions with thought restructuring (Haque, Thompson, & El Bassuni, n.d.; Knaevelsrud, Brand, Lange, Ruwaard, & Wagner, 2015).

Given the impact of culture and religion on views of mental health and its manifestation, treatments are often culturally adapted to the needs of clients to comply with their beliefs and values (Soueif, 2001). On the other hand, awareness about psychology and psychiatry has increased in Arab societies over the past decades. Regardless of the effort to recruit clinical psychologists and create job opportunities, local professionals report that the field is not yet adequately developed in those countries. Raising awareness about the important role of psychologists in society and providing better training can help improve mental health services (Amer, 2013). Also, creating anti-stigma programs by providing mental health at the primary health care level may reduce mental health stigma (Almazeedi & Alsuwaidan, 2014; Dalky, 2012). Offering affordable mental health services and collaboration between clinics and governmental organizations can help promote clinical psychology and motivate individuals to seek treatment, especially in financially unstable populations such as refugees (Amer, 2013). Recently, the Kuwait Center for Mental Health established clinics staffed with psychiatrists and physicians at community health care centers; partnership and combined efforts may be the right way to increase mental health

awareness (Almazeedi & Alsuwaidan, 2014). Despite these complications, today clinical psychology is beginning to be viewed as an honorable and respected profession in these countries, suggesting that there is potential for progress.

Bahrain

Clinical psychology in Bahrain originated in the twentieth century when the first training programs were established in colleges. In 1966, the first program was initiated at the Teacher Training College; later, other institutions started introducing psychology courses (e.g., introduction to psychology, educational psychology, and developmental psychology). In 1978, psychology was represented as a separate division at the College of Arts, Science, and Education. Other psychology departments were established later at various universities, including the College of Education at the Bahrain University, the University of Gulf Polytechnic, and the University of Bahrain (Aluhran, 2002).

Recently, a growing number of psychology programs have developed in Bahrain, including the psychology department at the University College of Bahrain, which launched its first postgraduate degree in counseling psychology in 1994 and currently offers a master's degree. This program is dedicated to providing education for students and preparing them for careers as professional psychologists and in both academic and applied settings including research positions in governmental organizations, psychological institutions, clinics, and hospitals. The University College of Bahrain also provides training for professionals, which is usually completed by attending workshops and training courses led by specialists. Despite of this, the country does not have legislative requirements for training (Aluhran, 2002).

Egypt

The foundation of psychological psychotherapy practices was established in Egypt in 1929, and 20 years later clinical services were available for adults, adolescents, and children. To promote psychology as a profession, pioneers started to practice psychotherapy (Ramadan, 2004). For instance, Abdel-Aziz El-Koussy launched a psychological clinic for young adults at the Higher Institute of Education in Cairo, in 1934. Other pioneers included Mostapha Zewar, Somaya Fahmy, Marcus Gregory, and Mohammed Fathy (Amer, 2013). The first attempt to make psychology into an academic profession occurred with the launch of the *Egyptian Journal of Psychology* in 1945. In this period, psychologists started to use therapeutic approaches including psychoanalysis and humanistic and behavior therapy. These models were brought to Egypt by psychologists who were trained abroad (e.g., the United Kingdom, France, Switzerland, and the United States; Amer, 2013). Dr. Sabry Girguis introduced clinical psychology to Egypt in the early 1950s when he established an outpatient clinic

called Helmeya in Cairo. This hospital still exists, and today it is one of the Ministry of Health Hospitals. The first attempt to establish official requirements and regulations for psychologists in the country occurred in 1956, when a law was passed declaring that psychotherapy practice required a license from the Egyptian health authorities in addition to training and a degree. Clinical psychology as a profession started in the 1960s and 1970s; in 1974, the first independent department of psychology was established (previous psychology departments were combined with philosophy departments) at Cairo University by Professor Moustafa Souief and at Ain Shams University by Professor Moustafa Zewar (Ramadan, 2004). In the 1970s and 1980s other universities around the country also established psychology departments. In 1986, the Egyptian Ministry of Health established a policy to engage psychologists in mental health practices and work with psychiatrists within these institutions (Soueif, 2001).

As of today, more than 200 clinical psychologists are working in Egypt in addition to many more who serve as general psychologists. Psychologists mainly work in public hospitals, private practices, government and military institutions, schools, and community centers (Ahmed, 2004). Egyptian universities offer undergraduate and graduate degrees in psychology. Students usually complete a bachelor's degree in 4 years, a master's in 2–4 years, and a doctoral degree in an additional 3–4 years (Amer, 2013). To become a psychologist in Egypt, students are required to complete a 4-year Bachelor of Arts program with a major in psychology, complete four accredited courses and a 2 year internship at a psychiatric hospital to qualify for work with clients. Another option is for students to complete master's and doctoral degrees in clinical psychology. This training and accreditation is required to receive a license from the Ministry of Health. Some individuals acquire a license automatically by having a PhD and serving as a faculty member at a university (Ahmed, 2004). Some of the theoretical orientations that clinical psychologists practice in Egypt include psychoanalysis, cognitive behavioral therapy (CBT), group therapy, family therapy, art therapy, and dialectical, interpersonal, supportive therapies. However, most clinicians perceive CBT as the dominant approach (Amer, 2013).

Iran

The early twentieth century also brought psychology to Iran: in 1933, the first psychology laboratory was opened, and in 1938, psychology courses were first offered at Tehran University. In 1965, the first academic program of clinical psychology was established in Tehran University's Department of Psychology; in 1966, Dr. Saeed Shamloo published the first book on clinical psychology in Persian. In 1970, the first clinical psychology master's program was developed at the Rouzbeh Psychiatric Hospital, and later other master's programs were established, such as the program at the Welfare and Rehabilitation Sciences University (Behrooz, 2013).

The clinical psychology programs in Iran are accredited by the Board of Clinical Psychology. To become a clinical psychologist in Iran, individuals are required to

obtain a master's or doctoral level degree. The academic requirements of a master's in clinical psychology include completing 32 course credits, a thesis, and practical training. The doctoral degree requirements include completing 42–50 credits of course work and a 1-year internship as well as submitting a dissertation and passing an examination. Clinical psychologists are licensed by the Iranian Psychology and Counseling Organization, which also oversees the work of clinical psychologists and provides exclusive rights for clinicians and clients. Licensing requirements for clinical psychology in Iran involve an interview and an examination. According to the 2014 data reported by an interviewee, approximately 7500 master's clinical psychology students and 160 doctoral students were enrolled in Iranian universities.

Clinical psychologists in Iran often work in private practices, academic settings, and community services. The various theoretical approaches they use in their work include CBT, psychoanalysis, rational-emotive therapy, and humanistic approaches as well as family therapy, short-term psychotherapy, couples therapy, group therapy, and schema therapy. Since the late 1980s, however, CBT has become the dominant approach for most clinical psychologists and training programs in Iran. CBT was first introduced in Iran in 1975 and appears to play a critical role in the development of master's programs in clinical psychology, as the first programs at Tehran University and Roozbeh Hospital focused on CBT. Many Iranians perceive CBT as compatible with their culture because the approach associates thoughts with emotions, and the Iranian culture encourages one to be particularly conscious of one's thought process and internal emotional state. This explains the increase in the interest of CBT over the past decades. Training in CBT is provided by private, governmental, and nongovernmental organizations, and it is used to treat various mental and physical disorders and problems (e.g., eating disorders, addictions, asthma, and chronic pain; Behrooz, 2012).

Iraq

Clinical psychology was first introduced in Iraq in 1955 through the Psychological Research Center in Baghdad. The degree obtained at the center is provided by the Al-Mustansiriyah University, College of Arts. In 1998, clinical psychology was first accepted as a separate profession through the collaboration and effort of professionals and students in the discipline. According to the World Health Organization (WHO) report in 2006 (WHO-Aims Report on Mental Health System in Iraq, 2006), 16 psychologists worked in mental health services and two students graduated from a psychology program.

Iraqi hospitals and university do not have a clinical psychology specialization; therefore, no clear distinction exists between clinical psychologists and other mental health professionals such as social workers and counselors. Most psychologists in Iraq have a master's degree and some training. Some of the academic requirements to be recognized as clinical psychologist include pursuing a master's degree in clinical psychology. The master's program involves completing courses (e.g., advanced

courses, theories of personality, neuropsychology, research methods, and general and abnormal psychology) and 2 years of practical training at a mental health hospital. The main theoretical orientation practiced by psychologists in Iraq is CBT, although many professionals practice the psychodynamic approach and others receive training in trauma therapy (e.g., Eye Movement Desensitization and Reprocessing; EMDR) to treat traumatized clients. Most psychologists work in government mental health services and in academic settings, as private practices do not yet exist in Iraq.

Israel

Psychology was first introduced in Israel in 1920 when a group of psychoanalysts immigrated to the country with the encouragement of Sigmund Freud. The growing interest in the psychoanalytic approach in that period led to the establishment of the Jerusalem Psychoanalytic Institute and Society in Jerusalem. The first time psychology was offered as an academic subject was in 1933, at the Hebrew University of Jerusalem. A year later, in 1935, the Professional Counseling Institute was established in three locations: Jerusalem, Tel-Aviv, and Haifa. The first psychology program was established at The Hebrew University of Jerusalem by Professor Enzo Bonaventure, in 1939, but he was killed in an attack on the way to the university in 1948. The psychology program was formally reestablished in 1957 by Professor Saul Kugelmass. Because of rapidly growing interest in counseling and the need to develop mental health care, in 1944 the Hadassah Institute for Counseling was established to encourage individuals to engage in mental health practices, and in 1950 the first educational psychology services were launched by the Ministry of Education. In 1957 the Israel Psychological Association was established. In 1960 the first clinical psychology department was launched at The Hebrew University, and, a year later in 1961, the second was founded at Bar Ilan University in Tel-Aviv. Five years later, in 1966, psychology programs were established at Tel Aviv University, Haifa University, and Be'er Sheva University. The first psychotherapy training program was established at Tel Aviv University in 1971 to train and accredit mental health professionals in the analytical approach.

In 1977 the Psychologist Act, which regulates the profession and oversees the licensing process of clinical psychologists in Israel, was passed as a government statute. According to this legislation, in order to practice psychotherapy, every psychologist is required to enroll in the psychologist register, an organized register managed by the Ministry of Health that documents all psychologists working in the mental health sector in Israel. Israel is currently undergoing a major mental health reform in which health maintenance organizations are taking over responsibility for most outpatient services from government supported community mental health centers. The role of clinical psychologists was central in the community mental health centers in terms of both service provision and training, and there are great unknowns about how the reform will impact clinical psychology. To become a clinical psychologist in Israel, an individual must have at least a master's-level degree in clinical psychology (which

includes a thesis and practicum), complete a 4-year half-time internship in a clinical setting, and obtain a license by passing an oral exam. In order to sit for the exam, one must have administered a certain number of assessments including the Rorschach, an intelligence test, and others measures (often other projective tests). For many years, 20 batteries had to be administered in addition to treating patients for 3 years in an outpatient setting and for 1 year in an inpatient setting in half-time internships. Recently, there have been moves to reduce the number of assessments and expand the repertoire of tests to be more guided by the referral question and reductions in the numbers of Rorschach and IQ tests required.

At the end of 2014, there were 11,500 psychologists in Israel, and today there are more than 3800 clinical psychologists. For the population, this is the highest number of psychologists per population in the world. According to our calculations, there are approximately 144 psychologists per 100,000 people in Israel. In comparison to the WHO 2014 data, the next highest number of psychologists per 100,000 in the world is in Netherlands (90.76), and then Finland (56), (World Health Organization, Substance Use of Mental Health, 2014). In the United States, the number per 100,000 is 29.63. Thirteen colleges and universities offer a bachelor's degree in psychology; eight also offer master's degrees, and five offer doctoral degrees. Clinical psychologists in Israel work in private practices, hospitals, academic settings, the army, and government organizations, to name a few. The main theoretical orientations are psychodynamic (including a wide range of orientations including interpersonal, self, object relations, and more) and CBT; the psychodynamic approach is dominant among clinical psychologists in Israel, but there is growing interest in CBT. Systems approaches are used at times with children, often with integration of other orientations. The client-centered/humanistic approach is less common and not formally recognized in Israel in terms of its status compared to other orientations.

Culturally, Israel is an extremely diverse country. The population includes multiple religions and many different cultural and ethnic backgrounds. Therefore, it is difficult to describe any single adaptation that would need to be made to treatments. Overall, the population of Israel includes people of multiple religions (Judaism, Islam, Druze, Christians, Bahai, and others). The largest population is Jewish, with 20% of the Jewish population being Ultra-Orthodox. In addition, there are many first, second, and third generation immigrants from around the world, approximately half from Europe and half from other parts of the Middle East and Africa. Each community has a different relationship to clinical psychology. Ultra-orthodox Jews, Arab-Israelis, and Ethiopian immigrants tend to have greater stigma about mental health and seeing mental health professionals because of their more traditional religious beliefs. There is more openness to treatment, though still significant stigma in the secular and modern religious communities which make up more than half of the population. There have been a number of articles written on the manifestations of psychopathology and how to adapt treatment to various populations within Israel (e.g., Bar-El et al., 2000; Dwairy, 2009; Greenberg & Witztum, 2001; Hess, 2014; Huppert & Siev, 2010).

Jordan

Psychology was introduced to Jordan in 1970, when psychology departments were first established. In 1980, the National Center for Educational Research was founded to promote interests and a wide range of research in the field (Gielen, Adler, & Milgram, 1992). In 1986 a mental health policy was created in Jordan and in 2011 the policy was updated. The aim of the updated policy is to offer mental health services with an emphasis on cultural adaptations, employing mental health professionals, and reducing mental health stigma (WHO Mind Mental Health in Development, 2013). In 1990, clinical psychology was brought to the country by number of clinical psychologists who had studied abroad, but the profession was officially accepted in the beginning of the twenty-first century. In 1994, a national mental health program was developed to increase mental health awareness and provide professional training, and in 2003 mental health legislation was introduced (Mental Health Atlas, 2005). Currently, undergraduate and graduate programs in psychology are offered at universities in Jordan such as the University of Jordan in Amman, Yarmouk University in Irbid, and Mutah University in Kerak (Gielen et al., 1992).

Currently there are less than 20 licensed clinical psychologists in Jordan. According the regulations, to become a clinical psychologist is Jordan, an individual is required to have a master's level degree in clinical or counseling psychology and 2 years of clinical experience. The main therapeutic approach among clinical psychologists in Jordan is CBT and they often work in private practices and public practice and centers. In 1995 Jordan established a professional association called the Jordanian Psychological Association (JPA), based in Amman. The aim of the association is to support and protect professionals and increase mental health awareness in community. Some of JPA's contributions include holding conferences and conducting workshops to train professionals and creating guidelines in partnership with the ministry of health in Jordan.

Kuwait

Psychology in Kuwait emerged in the early 1950s, and during that period some psychological services were offered to the public. In 1966, the first psychology and education department was established at Kuwait University, and in 1980, the university announced that the Psychology and Education Department would split to become independent departments. At first, the university offered graduate and undergraduate degrees, but in 1975 it started offering only graduate programs. In 1972, the Department of Psychological Services was initiated, which offered psychological services and engaged graduate students in the mental health sector (Gielen et al., 1992). Mental health in Kuwait is included in the primary health care system. In 1957, a mental health policy was developed in the country, and 40 years later, in 1997, a mental health program was created (Mental Health Atlas, 2005).

In 1998, Dr. Vincenza Tiberia, an American clinical psychologist was the first to be brought to Kuwait to train and supervise Kuwaiti psychologists. Some of Dr. Tiberia's contributions include implementing and teaching ethics according to the American Psychological Association (APA) guidelines, establishing procedure manuals, and promoting training programs with the help of other psychologists. There are no guidelines for becoming a psychologist in Kuwait. However, most psychologists have a doctoral degree (including at least 2 years of training) and additional training after the degree is completed. Also, psychologists in Kuwait are not required to receive a license before starting to work, and only a small number are licensed. Due to the lack of regulation, there is a misconception regarding who can be a psychologist, and many people decide to call themselves psychologists even if they do not have formal qualifications.

Clinical psychology is in the early stages of development in Kuwait, with few government services in some parts in the community. The need to create a professional ethics code and the desire to establish a national association to promote mental health in the Middle East led to the founding of the Middle East Psychological Association (MEPA) in 2010. This organization is based in Kuwait and recognized by the APA. Some of MEPA'S responsibilities include emphasizing the importance of the psychologist's role, offering professional training, and creating psychological services for the community.

Lebanon

The history of psychology in Lebanon goes back to the mid twentieth century. Between 1950 and 1960, various therapeutic approaches were introduced in Lebanese medicine, including family and adult therapy. Later, mental health institutions were established to promote mental health care, such as the psychiatric hospital of the Red Cross; the Institution for Development, Research, Advocacy, and Applied Care (IDRAAC); and the Medical Institute of Neuropsychological Disorders (MIND). Dr. Mounir Chamoun first introduced clinical psychology as a discipline at Saint Joseph University in 1980. In 2003, the Lebanese Psychological Association was established, and in 2011 Dr. Brigitte Khoury founded the Arab Center for Research, Training, and Policy Making at the American University of Beirut (Khoury & Tabbarah, 2013).

There are approximately 200 students with master's-level degrees in psychology or clinical psychology in Lebanon. Currently, there is no clear licensing process or set of guidelines for clinical psychologists in Lebanon because no official legal entity exists to oversee the discipline. In the past, psychologists were classified as clinical psychologists based on the university they attended and its regulations. At this time, the Lebanese Psychological Association, in collaboration with the Ministry of Health, is working on a decree to define requirements, roles, and responsibilities of clinical psychologists. The Lebanese Psychological Association recently declared new requirements for clinical psychologists, including a master's-level degree in clinical psychology and 400 h of clinical work. The clinical program

established in the American University of Beirut's psychiatry department is the first program to provide a 2-year training and supervision practicum.

Clinical psychologists' employment settings include private practices, private hospitals, private schools and universities, and non-governmental organizations. Often, practitioners teach and provide training, conduct assessments, and deliver treatment. Clinical psychologists use two main approaches in their work: psychoanalysis modeled on the methods used in the French system (e.g., Lacan), and CBT. CBT's development and acceptance has recently been recognized in Lebanon: the Lebanese Association of Cognitive and Behavioral Therapy was established in 2002 and today is recognized as a part of the European Association of Cognitive and Behaviour Therapies (EABCT). As of today, there is no official program for training in CBT; however, training is available at hospital psychiatry and clinical psychology departments. CBT pioneers in Lebanon have been collaborating with experts from around the world to develop workshops and seminars to better educate and train candidates. Official governmental organizations are working with CBT pioneers to increase awareness of CBT and provide official academic and professional training for candidates (Karam, 2015).

Oman

In the late 1980s, the first department of psychology was established at Sultan Qaboos University in Muscat with the help of some Egyptian psychologists (Baker, 2012). The department's mission was to provide psychological services and training for students and teachers, and the department's staff consisted of academic professionals from abroad (e.g., Egypt). Also, at that time a behavioral science program in the medical college that included psychology was offered to educate medical students; because of a shortage of qualified and credentialed professionals, the psychology courses were taught by the academics in the college (Al-Adawi et al., 2002). Psychology training in Oman was provided by the medical school and at the College of Education at Sultan Qaboos University (Al-Adawi et al., 2002).

Mental health care in Oman is a part of the primary health care system. A number of mental health resources are available in the Omani community. A mental health policy was established in 1992 with the mission of providing treatment for various psychological problems. A substance abuse policy was created in 1999 to provide treatments for abuse problems. A national mental health program was founded in 1999 to offer mental health services in the community and train professionals (Mental Health Atlas, 2005).

Most clinical psychologists in Oman have master's degrees, but very few psychologists hold a doctorate. Clinical psychology is not yet fully established in Oman; the profession is not defined, and there are no required academic or training requirements to become a practitioner. Some of the theoretical orientations practiced among clinical psychologists in Oman include CBT and acceptance and commitment therapy (ACT). Clinical psychologists in Oman provide therapy and

conduct assessments, and they often work in private practice or in public centers and clinics.

The field of psychology in Oman is not as developed as it is in other countries. Some of the limitations of practicing psychology in Oman include the need for formal training programs, defining academic requirements, and establishing legislation and rules to better define the role and responsibilities of clinical psychologists (A. Sultan, personal communication, January, 2014). Owing to the lack of psychological services and an increase in psychological problems among the Omani people, through the efforts of national psychologists, the psychiatry department at the Oman Medical College is currently offering psychological treatment in addition to the other services (Al-Adawi et al., 2002).

Palestinian Territories

Dr. Mubarak Awad, considered one the main pioneers of psychology in Palestine, first introduced psychology in the Palestine Territories in 1983. One of his major accomplishments was initiating the Palestine Counseling Center, the first institute to provide psychological service. The organization offers training for students and therapy for clients (Nashashibi, Srour, & Srour, 2013). In 1987, national and global organizations were established to treat individuals' symptoms resulting mostly from traumatic events. Some of these institutions include the Gaza Community Mental Health Program and Medicines Sans Frontiers (MSF). In 1996, the Ministry of Health established the first psychology programs at universities; the aim of these programs was to integrate psychologists into educational institutions (Nashashibi et al., 2013).

There are no distinctions between clinical psychology, general psychology, and social work in the Palestinian territories. Moreover, distinguishing clinical psychology from social work and counseling psychology is quite challenging; individuals who obtain an undergraduate degree in psychology or social work call themselves clinical psychologists. Professionals with bachelor's, master's, and PhD degrees have the same responsibilities and work in the same settings. In 2015, Al-Quds University initiated the first effort to establish a clinical program by offering a community mental health program with a concentration in psychotherapy. In the Palestinian territories, there are five universities with psychology programs, including al-Quds, An-Najah, Birzeit, Bethlehem, and the Islamic University of Gaza. Because clinical psychology is not yet developed enough in the Palestinian territories, psychologists from Palestine search for training opportunities outside the country to gain the appropriate experience (Costin, 2005).

Much of the focus of psychologists in the Palestinian territories is on the treatment of trauma symptoms; some of these approaches include eye movement desensitization and reprocessing (EMDR) and expressive therapy (Nashashibi et al., 2013). Other approaches are common, as well. For instance, some organizations provide training for psychologists (mainly in CBT) based on organizations' requirements, but there is no clarified registration regulation for psychologists. The Gaza

Community Mental Health Program (GCHP) was founded in 1990 to provide therapy and training. Psychologists who desire to work at the Ministry of Health must obtain accreditation as a psychologist or social worker, but most professionals prefer to work at non-profit organizations. Nongovernmental organizations also provide training for graduate students (Nashashibi et al., 2013). Most psychologists and social workers work in nonprofit organizations, while some work at schools (limited budgets prevent greater employment in schools), community centers, and hospitals (social workers more than psychologists). Social stigma is associated with seeking treatment, and negative generalizations are made about people who receive therapy or counseling. People with mental illness are often stigmatized and perceived as "crazy"; therefore, there is shame in seeing a psychologist (Costin, 2005).

A wide gap in mental health care exists between Palestine and other countries. Our interviewees suggested that authorities need to establish an official entity that defines the roles, responsibilities, and requirements of psychologists. Recently, there is an aim to raise awareness of mental health and promote psychology in the workplace; the Palestine Authority's National Mental Health Centers are developing community health care plans and services by modifying Western methods for Palestinian culture to respond to clients' psychological needs (Costin, 2005).

Qatar

In 1973, psychology was first announced as an independent discipline in Qatar. In 1977, Qatar University was established and introduced two psychology departments: the Department of Psychology and the Department of Educational Psychology. In 1980, the Center for Educational Research, where a variety of research is conducted, was founded at Qatar University (Gielen et al., 1992). In 1980, a mental health policy was created to promote treatment. Later, in 1986, a substance abuse policy was established, and 1990 saw the introduction of a national mental health program that centers on providing health care and regulating counseling services (Mental Health Atlas, 2005).

As in Kuwait, clinical psychology is being developed in Qatar and some services are offered in the community. Clinical psychologists in Qatar face problems concerning insurance and professional risk because there is no official governmental licensure. This issue may pose a challenge to clinical psychologists in that they aim to work ethically and wish to receive government support.

Saudi Arabia

The establishment and development of clinical psychology in the Kingdom of Saudi Arabia (KSA) occurred in the early 1980s. In 1982, Dr. Othman Altoal, who served as the director of mental health in the KSA at that time, first introduced clinical

psychology to the country. Later, Dr. Saeed Wahass, considered the pioneer of clinical psychology in the KSA, initiated the opening of clinical psychology units at hospitals in the kingdom.

In Saudi Arabia, clinical psychology is considered part of the liberal arts. The shortage in professions and services led to the launch of a new clinical psychology program for students who obtain a Bachelor of Science at the Princess Noura University, College of Health and Rehabilitation Sciences. The academic requirements of the program involve completing 137 credits of course work and a 1-year clinical internship. To become a clinical psychologist, students are required to pursue a bachelor's degree in psychology and train for at least 3 months at a hospital. Recently, the aim has been to require a more advanced degree to become a clinical psychologist; therefore, the first master's program in clinical psychology was established at the University of Dammam. In addition to academic development, the Saudi Commission for Health Specialty has established accreditation regulations for clinical psychologists. This is considered the first effort to create an official training guideline. According to the Saudi Commission for Health Specialties, Professional Classification and Registration of Health Practitioners Manual (6th Edition, 2015), students can specialize in clinical psychology if they have a bachelor's degree in psychology and 3 years of clinical work under supervision (Guidelines of professional classification and registration for health practitioners, 2015). Because the protocols have only recently been established in 2014, it is difficult to obtain accurate numbers of professionals who fit the category, but there are more than 1500 psychologists (mostly holders of only a undergraduate degree), of whom only about 30 individuals are highly trained. As in many other countries in the Middle East, CBT is the dominant therapeutic approach. Some hospitals have maintained family therapy programs for 7 years now. Clinical psychologists often provide psychotherapy, administer neuropsychological assessments, and teach courses and workshops. Their employment settings include working in public and private hospitals, private practices, and academic settings. One example of the discipline's rapid growth in the KSA is the establishment of the clinical psychology department at King Fahad Medical City, which has integrated clinical psychologists as mental health providers (Chur-Hansen et al., 2008).

Syria

Psychology emerged in Syria around the late 1940s when psychology courses were taught as a part of the philosophy and education departments. Thirty years later, in the 1970s, psychology departments were introduced at universities, offering undergraduate degrees in psychology. The pioneers who helped develop and promote the growth of this field are H. el-Gahli, Sami el-Dorroby, and F. H. Akil (Gielen et al., 1992).

In Syria, stigma regarding psychological distress and illness is prevalent; it is not acceptable for men (but is for women) to express and reveal emotions because it is considered a sign of weakness. Also, as in other Arab countries, mental illness is

perceived as shameful because of the risk of being labeled "crazy." Combining mental health services with more acceptable services such as primary care could reduce the stigma associated with mental health care in the Syrian community and improve the quality of life of individuals with mental disorder (Hassan et al., 2015). Given the current civil war in Syria, it is hard to describe the current services provided there.

Turkey

The history of psychology in Turkey started in 1915, when psychology was first recognized as a discipline (Poyrazh, Dogan, & Eskin, 2013). The first psychology courses were introduced as part of university philosophy departments in 1930. In 1970, early psychology studies centered on the Freudian approach, and the first clinical courses were taught based on psychodynamic methodology. In 1980, Isik Savasir founded the first cognitive behavioral program in Hacettepe. This program was one of the leading training programs for clinical psychologists and had a major influence on the discipline because it led to the establishment of other clinical psychology programs in Turkey such as those at Ankara University and Middle East Technical University. In 1984, the Institute for Higher Education recognized other psychology courses, leading to major developments in clinical psychology. In 2011, clinical psychology was first accepted as a separate profession in Turkey, and a law was created to make explicit the requirements, roles, responsibilities, and work conditions of clinical psychologists. The Ministry of Health accomplished this by working with representatives from academic and professional psychology fields and with leaders from the Turkish Psychological Associations. Despite this achievement, as of today Turkey does not have a law that defines the profession of clinical psychologist.

As of today there are approximately 3000 clinical psychologists in Turkey; however, the country does not have a registration system, and providing accurate data can be challenging. Based on the Ministry of Health law, clinical psychologists are required to complete at least 6 years of education and training in both psychology and clinical psychology. Currently, about ten graduate programs exist in clinical psychology in Turkey (Poyrazh et al., 2013). The academic requirements include an undergraduate degree in psychology and a master's degree in clinical psychology. Students also can pursue an undergraduate degree in counseling psychology and a master's and doctoral degree in clinical psychology.

Clinical psychologists in Turkey practice different theoretical orientations, but their specific orientation depends on their training. The main approaches are CBT, psychodynamic, and humanistic. Despite this variety, CBT is the dominant oreintation. CBT is used to treat various adult and child mental disorders including anxiety disorders, depression, eating disorders, schizophrenia, and bipolar disorder as well as sexual and addiction problems. The Turkish Association of Cognitive and Behaviour Psychotherapies (TACBP) is the only CBT organization in Turkey. It was initiated in 1995 and currently has hundreds of members. TACBP provides training

in CBT for professionals by offering courses, seminars, and workshops according to the European Association Behavioral Cognitive Therapies (Sungar, 2010). Clinical psychologists in Turkey work in hospitals, government organizations, and private clinics. Some of their responsibilities include conducting assessments and testing, offering treatments and interventions (both group and individual), providing training and consultation, and working in research or academic settings.

In Turkey, religious beliefs and ideas are thought to have a positive influence on clinical psychology by helping clients to manage their traumatic symptoms in treatment. Nonetheless, in the past, cultural and social factors negatively affected clinical psychology. Individuals previously viewed the use of medication to treat mental illness as a stigma. Recently, however, more people have become aware of the fact that mental disorders could develop as a result of life events and experiences and have come to view seeking pharmacological treatment as acceptable. Despite these developments in clinical psychology, a need exists to create more master's programs and train clinical psychologists in Turkey (Kayaoğlu & Batur, n.d.).

United Arab Emirates

Psychology was first introduced in the United Arab Emirates (UAE) in 1971 at UAE University, and in 2004 it was first recognized as a separate discipline. The first accredited graduate program in clinical psychology was established at the United Arab University (UAEU) in 2011, and later on another undergraduate program began at the New York University Campus in Abu Dhabi.

The core of this program is based on research and the goal of training students.

Until 2012, no clear requirements existed for clinical psychologists; individuals with any psychology degree could refer to themselves as clinical psychologists. In 2012, new legislation was created to define the academic and professional requirements and employment settings of clinical psychologists. Clinical psychologists are required to obtain master's degrees in clinical psychology and complete clinical work (Amer, 2013). Two government bodies are responsible for the regulation of clinical psychology in the UAE: Dubai Health Authority (DHA) and the Health Authority of Abu Dhabi (HAAD). These two units have almost similar guidelines. The main requirements include a doctoral or master's degree and completion of an internship and a written exam.

According to Hague and his colleagues, 32% of psychologists have master's degrees in psychology in comparison with 33% who have doctoral degrees. There are a variety of theoretical models practiced among UAE psychologist; 74% of psychologists use eclectic theoretical models, 19% use cognitive behavioral therapies, and only 3% use the psychodynamic approach (Haque et al., n.d.). Clinical psychologists in the UAE are engaged in clinics, schools, and hospitals.

Yemen

Yemen's first academic clinical psychology program was established in 2003 by the Ministry of Health and the Yemeni Medical Board. Two levels of degree in clinical psychology are available in Yemen: bachelor's and master's. The Ministry of Health's department for psychology is responsible for providing academic involvement, and the Yemeni Medical Council grants clinical training. There are more than 14 departments of psychology in Yemini Universities (Saleh, 2008a, b).

In 2009, 300 psychologists (1.5 per 1,000,000) worked in Yemen; out of this number, 135 are employed in academic institutions, 75 in mental health services, and 45 in social work (Cite). Data from the Yemeni Health Association (YMHA) showed the numbers of degree holders in psychology from 2002 to 2006: 51 held doctoral degrees, 159 held master's degrees, and 3370 held bachelor's degrees. Most of these psychologists were employed in academic settings, governmental organizations, and social work services (Saleh, 2008a, 2008b). Some of the services they provided include psychotherapy (in both private and public settings) and counseling at mental health services. In Yemen, the focus of the National Mental Health Program and Non-Governmental Associations (NGOs) is similar to that of other mental health services: to create official organizations that emphasize the role of psychologists. The mental health telephone counseling program initiated in 2000 by the Yemeni Mental Health Association, and Aden University has attempted to raise the awareness of psychologists' values and responsibilities. The Hotline for Psychological Aid (Aden) represents the first resource of it is kind in the Arab world. According to 2007 data, more than 4000 calls were received reporting mental disorders and psychological problems (Saleh, 2008a, 2008b). Later on, many other hotline and psychological counseling services were established, including the Hotline for Psychological and Legal Support (Sana'a), the education and psychological counseling center at Sana'a University, the student counseling center at Taiz University, and the Hotline at the Mental Health Cultural Health Center Sana'a (Saleh, 2011).

Some of the obstacles clinical psychologists face in Yemen includes the need for academic program training and accreditation. The mental health field is growing rapidly in Yemen, and the establishment of the different psychological services and organizations contributes to the success of programs to deal with violence and increase the awareness of mental health in the country to make the profession more accepted and honorable (Saleh, 2008a, 2008b; Saleh and Makki, 2008).

Conclusion

The Middle East marks the meeting point between East and West, where the various countries create diverse and wide-ranging cultures and traditions. It is the birthplace of the three major religions: Judaism, Islam, and Christianity. Islam is the dominant religion, and Islamic traditions and values are practiced in most Middle Eastern

Table 1 Number of psychologists working in the mental health sector in the Middle East.

Country	Population 2014 (in million)	Psychologists working in the mental health sector (2014)
Bahrain	1.3	9
Egypt	89.5	107
Iran	78.1	3959
Iraq	34.8	31
Israel	8.2	11,502
Jordan	6.6	18
Kuwait	3.7	77
Lebanon	4.5	74
Oman	4.2	15
Palestine Authority (West Bank and Gaza)[a]		36
Qatar	2.1	26
Saudi Arabia	30.8	425
Syria	22.1	26
Turkey	75.9	1085
United Arab Emirates[b]	8.7	45
Yemen[b]	24.2	41

Note: Total population data is from the World Bank census report (The World Bank, 2015) and number of psychologists is calculated based on the rates (per 100,000) provided by the World Health Organization
[a]Data Available as of 2006
[b]Data Available as of 2011

countries. For this reason, the Middle East is viewed as traditional in comparison with other regions around the world. However, there does not seem to be a relationship between traditions and providing psychological treatment, because psychology is an acceptable and common field in some countries, such as, Israel, Iran, and Turkey (Table 1). Notably all three of these countries have histories of being run by secular governments for a significant period of time, which may have provided more support for the entry of psychology into their societies. Some other countries are realizing the importance of introducing psychology, and are working to develop culturally adapted concepts that are acceptable to the wider public. However, stigma toward mental health is prevalent among Middle Eastern societies, and it appears to negatively affect those seeking treatment (and also prevent many from seeking treatment). Therefore, there is a need to decrease stigma and increase mental health awareness to improve the health and mental well-being of individuals. Given the important role of Islam in most of the Middle East, it seems important to work on developing culturally adapted models of clinical psychology in order to facilitate the introduction of clinical psychology at a greater scale in the Middle East. It is difficult to obtain systematic information about clinical psychology in the Middle East, and therefore we based much of our report on individuals who were surveyed. We are aware of the limitation of reporting in such surveys; thus, a more systematic investigation is needed to better describe the status of clinical psychology in the

Middle East and to make more specific policy recommendations on how to advance clinical psychology in the Middle East. Due to the many conflicts currently occurring in the Middle East, there is a clear need to promote clinical psychology throughout the region.

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Ethics from a Global Perspective

Jennifer Prentice, Keith S. Dobson, and Janel Gauthier

The increasing globalization of our world has created a state where it is incumbent upon psychologists and relevant professionals to view psychological ethics from a global perspective. Professionals may encounter new challenges in the application of ethical principles when they work abroad or with different cultures at home. Such challenges will likely require knowledge, understanding, thinking, flexibility and creative problem-solving on the part of the psychologist, as he or she reframes what it means to behave professionally in the context of a local culture. By contrast, there are ethical principles that transcend specific cultures and can be applied globally. This is not to say, however, that ethical behaviors and standards that affirm the value of local cultures can also be applied globally to the discipline of psychology. Actually, those who have tried to do this, have failed. For example, a Task Force on Ethics was set up by the European Federation of Psychologists' Associations (EFPA) in 1990 with the aim of producing a common ethical code for psychologists in Europe. As stated in Lindsay, Koene, Øvereeide, and Lang (2008, p. 10), "It was evident at the first meeting of the Task Force in Copenhagen 1990, however, that this aspiration was unrealistic. A number of associations had their own codes, but not all. These codes had much similarity (Lindsay, 1992) but there were also a number of significant differences, mainly with detail rather than principle [...]. Nevertheless, each had been devised by the association in question to meet their

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specific requirements, and a common code might not ensure this occurred. Furthermore, in many cases (e.g., BPS) a vote of members was needed to change the code. Hence, it was decided that a common code was too difficult to achieve." (Lindsay et al., 2008, p. 10). Furthermore, a question arises not only as to whether or not establishing international ethical behavioral standards is feasible, but also as to whether it is desirable and in the best interest of worldwide societies. Perhaps what is needed is not a common code of ethics that includes enforceable standards of behavior, but a better understanding of the differences in the local and regional application of ethical principles across cultures. Cultures have much to learn from each other.

The current chapter elucidates the role of professional ethics in the discipline of psychology through a review of the emergence and development of ethics documents in psychology, and an examination of the contribution and significance of a universalist approach to ethics in a globalizing world. The chapter closes with a discussion on the gradual evolution and future of ethics in professional psychology from a global perspective.

Deontology: Are Ethics Universalist, Cultural or Personal?

The term "deontology" refers to the study of ethics that focus on the inherent morality of a behavior (Conway & Gawronski, 2013). The term "ethics" is derived from the Greek word *ethikos* which itself is derived from the Greek word *ethos,* meaning custom or character. It refers to a system of moral principles and values related to human conduct that defines what is morally right or wrong, i.e., what is good and bad behavior. In ethics, the term "ethical principle" refers to an overarching generic and widely held moral belief of what is "right" in interactions between human being and with the environment (Gauthier & Pettifor, 2012). Ethical principles are deeply rooted in our view of the purpose and meaning of life or existence in general.

Professional ethics can be conceptualized as universalist, cultural or personal (Conway & Gawronski, 2013; Falicov, 2014). A universalist perspective asserts that a relationship can exist between the global and local cultures and allow for ethical principles to transcend any one individual culture. More specifically, the values inherent in a code of ethics can be thoughtfully adapted and applied on a global scale. The universalist approach is similar to moral absolutism in that certain behaviors are predetermined to be either ethical or unethical based on a set of expectations determined by a profession. By contrast, a cultural perspective postulates that a universal approach subverts local cultures' norms, customs, beliefs, laws and values at the expense of the more dominant culture, which is responsible for the dissemination of a common code of ethics. The subversion of the local culture ultimately results in a type of cultural imperialism, and an appearance of globalism or universality which may be artificial. Finally, a personal perspective affords the individual the liberty to govern and determine his or her actions, judgements, and attitudes to be morally right or wrong. Professional psychological ethics presumes a common

perspective and a deontological ethical position. Thus, a code of ethics delineates a minimal set of expectations that are required of an individual to join a profession or, more generally speaking, an association or an institution.

Professional Ethics and a Universalist Perspective

The importance of a code of ethics or a code of conduct lies in the document's delineation of ethical principles, appropriate behaviors, and its ability to establish psychology as a profession. Professional psychological codes of ethics and codes of conduct guide psychologists' behaviors. Such documents are intended to support psychologists as they meet the public responsibilities of the profession. Professional codes of ethics further serve as an accountability framework to adjudicate complaints from the public. Ensconced within a professional code of ethics or a code of conduct is a minimal set of expectations that align with the norms and values of a particular culture, and are judged to be morally right. As such, psychologists are expected to act in congruence with the code of ethics or the code of conduct across time, context and clients. A corollary of this expectation is that psychologists may be expected to challenge the legal system when their legal obligations threaten the principles ensconced in the code of ethics or the code of conduct. It is expected that the code of ethics or the code of conduct supersedes a nation's laws when the risks associated with acting in accordance with the legal system outweighs the benefits to the client. Thus, it is the intention of a society's code of ethics or a code of conduct to ensure that psychologists exercise good moral judgment in the application of the ethical guiding principles or behavioral standards and that the code will pervade all psychologists' professional activities.

Ethics Documents in Psychology: Emergence and Development

Emergence

Codes that decree desired professional and societal behaviors have existed since Antiquity (e.g., *Code of Hammurabi*, *Hippocratic Oath*). Prior to World War II, however, ethics codes for psychologists did not exist. The convergence of several factors following the war contributed to the development of codes of ethics for psychologists. In 1945–1946, for example, the Nuremberg Trials disclosed to the world the extent of torture carried out by medical professionals in Nazi Germany. As a result, the public demanded greater professional scrutiny and stricter standards (Sinclair, Simon, & Pettifor, 1996), and the medical profession developed the *Nuremberg Code of Ethics in Medical Research* (1947). This code had tremendous influence

on the subsequent development of professional codes of ethics. The Nuremberg Code, in combination with the 1948 World Medical Association (WMA) *Declaration of Geneva* (WMA, 1948), and the WMA *Declaration of Helsinki* (WMA, 1964) formed the foundation for modern psychological research ethics in many countries in Europe and North America.

In 1945, the first legislation in the world for the regulation of psychological practice for the purpose of protecting the public from harm was passed in the state of Connecticut in the United States (Pettifor, Estay, & Paquet, 2002). The remaining American states, and provincial/territorial jurisdictions in Canada all followed suit. With legislated regulation, it also became essential to develop codes of ethics and the means to handle disciplinary complaints. In 1948, the American Psychological Association (APA) began working on the first code of ethics for psychologists, again to protect the public from harm. In the development of its first code of ethics, the APA depended heavily on continued consultation with its members on the kinds of ethical dilemmas that they encountered in practice. A final draft was adopted by APA in 1952 and published in 1953 (APA, 1953; Fisher, 2003). Since then, the code has been revised nine times. The latest revision was adopted by the APA Council of Representatives in 2002 (APA, 2002a, 2002b). Over the years, the APA Ethics Code has been used as model for the development of codes in other psychology jurisdictions, albeit with modifications to meet local needs.

Since the development of the first APA Ethics Code, more than 70 national codes of ethics have been developed globally (see http://psychology-resources.org/explore-psychology/standards/ethics/codes-of-ethics-of-national-psychology-organisations/ for a list), with the majority being developed in the past quarter-century. In addition, a number of psychological organizations have revised their codes. An examination of these codes reveals that some codes tend to be more prescriptive in nature and define in behavioral terms what one *must* or *must not* do as a psychologist without linking standards to specific ethical principles or values while other codes tend to be more aspirational in nature, and link standards to overarching principles and values. To reflect those differences, the term "codes of conduct" is used to refer to the former and the term "codes of ethics" is used to refer to the latter. These two terms are often mistakenly used interchangeably. They are, in fact, two unique documents. Codes of conduct are used primarily to govern behavior, while codes of ethics are used primarily to govern ethical-decision making; codes of conduct are enforceable, while aspirational ethical principles without further elaboration are not. Some codes of ethics such as the *Canadian Code of Ethics for Psychologists* (Canadian Psychological Association, 2000) explicitly require psychologists to engage in an ethical decision-making process, but they are the exceptions.

National codes that decree desired professional behaviors for psychologists are designed to provide ethical guidance to psychologists in all of their professional activities. While some of them emphasize the need to respect cultural differences and address cultural issues, none of them are designed to provide explicit ethical guidance to psychologists providing interventions or conducting research in other cultures. Since the emergence of national codes, ethics documents intended to be applied across national boundaries have been developed to meet new needs.

Regional Development

In the history of ethics documents for psychologists, the consideration of psychological ethics from a regional perspective is relatively new. In 1988, the Nordic countries (Denmark, Finland, Iceland, Norway, and Sweden) were among the first psychology regions to adopt a common code of ethics (Aanonsen, 2003). In 1996 and 1997, they revised this code to be consistent with the *Meta-Code of Ethics* of the European Federation of Psychologists' Associations (EFPA, formerly EFPPA—European Federation of Professional Psychologists' Associations (EFPPA, 1995). The revised version was adopted in 1998. Entitled *Etiske Prinsipper for Nordiske Psykologer* [In English: Ethical Principles for Nordic psychologists] (1998), it is organized around four main ethical principles: (a) respect for individual rights and dignity, (b) professional competence, (c) professional and scientific responsibilities, and (d) professional integrity. All the members of the Nordic psychological associations are obliged to follow these principles in their professional practice. The individual country associations or governments are responsible for the regulatory systems that include the investigation and adjudication of disciplinary complaints.

The development of the EFPA *Meta-Code of Ethics* (EFPPA, 1995, 2005) is also of great interest from a global perspective because it provides an example of how a regional federation of psychologists' associations with members from several different countries can promote common high standards for ethical practice (Lindsay et al., 2008). An EFPA Task Force on Ethics had been set up in 1990 with the aim of producing a common ethical code for psychologists in Europe. However, it was evident at the first meeting of the Task Force that this aspiration was unrealistic. Instead, the Task Force devised a meta-code that set out what each member association should address in their codes of ethics, but left it to the member associations to produce their own specific codes. Since EFPA adopted the *Meta-Code of Ethics* in 1995, national associations with existing codes have revised their codes of ethics as needed to be consistent with the *Meta-Code*. European Psychologists' associations without codes or in the process of developing a code have used or are using the *Meta-Code* as a template. The template comprises four ethical principles: (a) respect for a person's rights and dignity, (b) competence, (c) responsibility, and (d) integrity.

Another regional initiative was led by the Association of States and Provincial Psychology Boards (ASPPB), which represents 63 regulatory bodies of psychology in the United States and Canada. It provides services to its member bodies at the state, provincial and territorial levels in the two countries. The *ASPPB Code of Conduct* was first approved by the Board of Directors of ASPPB in 1990 and revised in 2005 (ASPPB, 2005). It has no freestanding regulatory force in itself. Rather, it serves as model, with each jurisdiction deciding how to use it. As the ASSPP ethics document is a code of conduct, the rules contained in the Code are essentially unambiguous concerning what behavior in the professional relationship functions is acceptable and what is not.

Another important regional initiative was the *Protocolo de Acuerdo Marco de Principios Éticos para el Ejercicio Profesional de los Psicólogos en el Mercosur y*

Paises Asociados [In English: Protocol of the Framework Agreement of Ethical Principles for the Professional Practice of Psychology in the Mercosur and Associated Countries] (1997), which was developed by the Comité Coordinador de Psicólogos del Mercosur y Paises Asociados [In English: Coordinating Committee of Psychologists of the Mercosur and Associated Countries] and endorsed in 1997 by six southeast countries of South America that had formed in 1991 a common market called "Mercado Común del Sur" or "Mercosur". Argentina, Brazil, Paraguay and Uruguay were full members, while Chile and Bolivia served as associated countries. The document reflects how psychologists from different countries without a regional association were able to develop an ethical framework for the professional practice of psychology. The framework includes five "general" ethical principles: (a) respect for people's rights and dignity, (b) professional competence, (c) professional and scientific commitment, (d) integrity, and (e) social responsibility. The Coordinating Committee of Psychologists is responsible to implement the *Protocol*. According to Ferrero (2008), the endorsement of common ethical principles has strengthened commitment for ethical behavior in the psychology community and helped Mercosur members and associated countries to develop their own ethics codes.

International Development

The interest of international psychology organizations to guide the ethical conduct of psychologists is not new. For example, in 1976, the General Assembly of the International Union of Psychological Science adopted a statement that requested each national member to enact a code of ethics to enable action against any member guilty of abuses against the rights of human beings (International Union of Psychological Science, 1976). However, the development of ethics documents by international psychology organizations is quite recent.

Four international psychology organizations have developed an ethics code or ethical standards explicitly for their own members. The International School Psychology Association (ISPA) was among the first, when it adopted a code of ethics for its members in 1990 (Oakland, Goldman, & Bischoff, 1997). In 2009, the ISAP undertook a revision of its code. The revised version was approved by the ISPA General Assembly in 2011 (ISPA, 2011). The ISPA code has an introduction followed by two separate sections: one on ethical principles and the other on professional standards. The ISAP expects school psychologists to exemplify the following six ethical principles articulated in the code: (a) beneficence and nonmalefience, (b) competence, (c) fidelity and responsibility, (d) integrity, (e) respect for people's rights and dignity, and (f) social justice. It is acknowledged in the introduction of the code that "the translation and manifestation of ethical principles and standards important to this code may vary somewhat between countries as a reflection of each country's norms, values, traditions, and laws."

The International Society of Sport Psychology (ISSP) developed standards to ensure respect for the dignity and welfare of individuals, athletes, professionals,

volunteers, administrators, teams, and the public in the provision of services by its members during the first half of the 1990s (ISSP, n.d.). These standards are grouped according to seven "general principles": (a) competence, (b) consent and confidentiality, (c) integrity, (d) personal conduct, (e) professional and scientific responsibility, (f) research ethics, and (g) social responsibility. The standards are expressed so that they can be applied to sport psychologists engaged in varied roles (Henschen, Ripoll, Hackfort, & Mohan, 1995). The code states clearly that the application of the ethical standards may vary depending upon the context (e.g., country and organization).

The International Association of Marriage and Family Counselors (IAMFC) adopted ethical standards for practice by its members in 2002. Since then, those standards have been revised twice. The latest revision was approved by the IAMFC Board in 2010 (Hendricks, Bradley, Southern, Oliver, & Birdsall, 2011). The 2010 ethical code is divided into nine sections: (a) the counseling relationship and client well-being, (b) confidentiality and privacy, (c) competence and professional responsibilities, (d) collaboration and professional relationships, (e) assessment and evaluation, (f) counselor education and supervision, (g) research and publications, and (h) ethical decision making and resolution, and (i) diversity. Each of the nine sections includes aspirations and principles. Members are required not to impose personal values on the families with whom they work, to become multiculturally competent, and to use indigenous healing practices when appropriate.

The International Society for Coaching Psychology (ISCP) adopted its first code of ethics in 2011 (ISCP, 2011). This code sets out the core values and guiding principles to inform the professional practice of coaching psychologists. It is based on six ethical principles called the "6 R's": (a) rights of individuals (rights to confidentiality, privacy, freedom of self-determination), (b) respect for the rights and dignity of all human beings, (c) recognition of standards and limits of competence, (d) relationships with others (good and based on trust), (e) representation (accurate and honest), and (f) responsibility (i.e., professional responsibilities to the coaches, the stakeholders, the society, general public, and to the profession of coaching psychology). These principles are said to be "interrelated".

Recognizing Fundamental Ethical Principles Through a Universal Declaration

Arguably, the single most important international development in the history of psychological ethics is the unanimous adoption of the *Universal Declaration of Ethical Principles for Psychologists* (herein referred to as the Universal Declaration) by the General Assembly of the International Union of Psychological Science and the Board of Directors of the International Association of Applied Psychology in 2008 (Ferrero & Gauthier, 2009; Gauthier, 2008a, 2008b, 2009). This adoption resulted from 6 years of extensive research, broad international consultation, and

numerous revisions in response to feedback and suggestions from the international psychology community. The development of the Universal Declaration is noteworthy as it reflects a successful process that attained maximum generalizability and acceptance. The most important components of that strategy involved inclusiveness, careful research, broad consultation, and respect for cultural diversity.

The Universal Declaration was developed by an international Ad Hoc Joint Committee working under the auspices of the International Union of Psychological Science and the International Association of Applied Psychology, chaired by Janel Gauthier (Canada). The Committee included distinguished scientists and practitioners in psychology from China, Colombia, Finland, Germany, Iran, New Zealand, Singapore, South Africa, United States, Yemen, and Zimbabwe. While many regions and cultures of the world were represented on the Committee, no attempt was made to have representation from all countries because a smaller group appeared more effective than a larger group for drafting a document. However, national organizations from over 80 different countries having membership in the International Union of Psychological Science had the opportunity to review and discuss reports and drafts of the Universal Declaration.

Research results helped to identify the principles and values that would be considered for the framework to be used to draft the Universal Declaration. First, comparisons were made among existing codes of ethics for psychologists from around the world to identify commonalities in ethical principles and values (Gauthier, 2002, 2003, 2004, 2005). Second, comparisons across disciplines, domains and throughout history were made to assess the "universality" of the ethical principles used most often to develop codes of ethics in psychology. For example, codes of ethics in other disciplines (e.g., sports, martial arts) were examined to identify the ethical principles and values espoused by other disciplines and communities (Gauthier, 2005); internationally accepted documents such as the *Universal Declaration of Human Rights* (United Nations, 1948) were reviewed to delineate their underlying moral imperatives (Gauthier, 2003, 2004); ancient historical documents from Babylon, China, Egypt, India, Japan, Persia, and so on were explored to identify the roots of modern-day ethical principles and values (Gauthier, 2006; Sinclair, 2005a, 2005b, 2005c).

The research-based framework and drafts of the document were presented for review and discussion at many international conferences and in many parts of the world, and formed the basis of both focus groups and symposia at international conferences. Further information regarding its development (e.g., background papers, progress reports and discussions on important issues) is available from the International Union of Psychological Science website (http://www.iupsys.org/ethics/univdecl2008.html).

While the methodology used to establish the Universal Declaration was unique and had many strengths, the discipline must be alert to the possibility of unintentional cultural bias. For example, the leadership for developing the document came largely from Western societies. Furthermore, many non-Western countries have used North American models to develop their own codes of ethics. Finally, English is the language for international discourse. However, it is not a universal language

and the meaning of words varies across cultures. Actually, one of the biggest lessons learned in developing the Universal Declaration was that words, or the translation of English words used in some cultures, can have unanticipated meanings in other cultures (Gauthier et al., 2010; Gauthier & Pettifor, 2011, 2012). For example, the word "others" may have negative connotations rather than being neutral. Differences in meaning across cultures are not always immediately visible and resolutions to differences is not always obvious. Hopefully, dialogue, research, and practice will continue to help to refine universal ethical principles.

Structure and Objectives of the Universal Declaration

The Universal Declaration (2008) includes a preamble followed by four sections, each relating to a different ethical principle: (a) respect for the dignity of persons and peoples, (b) competent caring for the well-being of persons and peoples, (c) integrity, and (d) professional and scientific responsibilities to society. Each section includes a statement defining the ethical principle and a list of the fundamental values that embody that principle. By accepting the principle, one also accepts the values that are inherent to that principle.

The four enumerated ethical principles and values contained in the Universal Declaration are presented in Table 1. This ordering of the principles from I to IV is meant to facilitate reference to various parts of the content of the Universal Declaration. Although there is no hierarchy involved in the numbering of the Principles, there is a relationship among them (Gauthier & Pettifor, 2012). For example, out of respect, psychologists treat others fairly and with compassion, provide competent care, practice with integrity and seek the collective good of society. Therefore, in the structure chosen for the Universal Declaration, no principle has priority over another, since all are manifestations of *respect*. This is why Respect for the Dignity of Persons and Peoples (Principle I) is described as "the most fundamental and universally found ethical principle across geographical and cultural boundaries, and across professional disciplines."

The Universal Declaration provides a universal moral framework and generic set of ethical principles to guide psychologists worldwide in meeting the ethical challenges of rapid globalization, a set of principles that encompasses all their scientific and professional activities as psychologists in a manner that also recognizes and may be used to address culture specific interpretations (Gauthier & Pettifor, 2012). The objectives of the Universal Declaration are defined in the second paragraph of the Preamble, which states:

> "The objectives of the *Universal Declaration* are to provide a moral framework and generic set of ethical principles for psychology organizations worldwide: (a) to evaluate the ethical and moral relevance of their codes of ethics; (b) to use as a template to guide the development or evolution of their codes of ethics; (c) to encourage global thinking about ethics, while also encouraging action that is sensitive and responsive to local needs and values; and (d) to speak with a collective voice on matters of ethical concern."

Table 1 Ethical principles and related values contained in the universal declaration of ethical principles for psychologists.

Principle I *Respect for the Dignity of Persons and Peoples*	Principle II *Competent Caring for the Well-Being of Persons and Peoples*	Principle III *Integrity*	Principle IV *Professional and Scientific Responsibility to Society*
Values • Respect for dignity and worthiness of all human beings • Non-discrimination • Informed consent • Freedom of consent • Privacy • Protection of confidentiality • Fair treatment/due process	Values • Caring for health and well-being • Maximize benefits • Minimize harm • Offset/correct harm • Competence • Self-knowledge	Values • Accuracy/honesty • Maximizing impartiality • Minimizing biases • Straightforwardness/openness • Avoidance of incomplete disclosure • Avoidance of conflict of interest	Values • Development of knowledge • Use of knowledge for benefits of society • Avoid misuse of knowledge • Promotion of ethical awareness and sensitivity • Promotion of highest ethical ideals • Ethical responsibilities to society

The Universal Declaration (2008) is not a global code of ethics or code of conduct, and that it is not intended to act as a code (Gauthier & Pettifor, 2011, 2012). However, it was designed to provide a moral framework of universally acceptable ethical principles based on human values across cultures and, accordingly, the values ensconced in the Universal Declaration are expected to be included in any psychological code of ethics or code of conduct (Gauthier et al., 2010).

It is also important to note that the Universal Declaration does not promulgate that certain behaviors are proscribed or compulsory for the ethical practice of psychology, as specific behaviors or rules that are indicative of ethical practice are frequently value-laden and culturally specific. Any guide to ethical behaviors contending to be "universal" could potentially defy some cultures' norms, customs, beliefs, laws and policies. Indeed, it is clearly stated that the "Application of the principles and values to the development of specific standards of conduct will vary across cultures, and must occur locally or regionally in order to ensure their relevance to local or regional cultures, customs, beliefs, and laws." (Universal Declaration, 2008, page 1, paragraph 4). This is why the Universal Declaration articulates principles and related values that are general and aspirational rather than specific and prescriptive.

Significance of the Universal Declaration

Psychologists in the twenty-first century are faced with expansion of their scope of practice and competency in order to work multi-culturally within their own country and culture, as well as to work internationally or globally. The Universal Declaration (2008) provides a common moral framework to guide and inspire psychologists toward the highest ethical ideals, as it states:

> "Psychologists recognize that they carry out their activities within a larger social context. They recognize that the lives and identities of human beings both individually and collectively are connected across generations, and that there is a reciprocal relationship between human beings and their natural and social environments. Psychologists are committed to placing the welfare of society and its members above the self-interest of the discipline and its members. They recognize that adherence to ethical principles in the context of their work contributes to a stable society that enhances the quality of life for all human beings."

While the Universal Declaration cannot be enforced, it has the potential to influence the development of local and global ethics. The mechanism whereby it can exercise this influence is described in the last paragraph of the Universal Declaration's Preamble, which reads:

> "The significance of the Universal Declaration depends on its recognition and promotion by psychology organizations at national, regional and international levels. Every psychology organization is encouraged to keep this Declaration in mind and, through teaching, education, and other measures to promote respect for, and observance of, the Declaration's principles and related values in the various activities of its members."

This mechanism is the same as the one whereby the *Universal Declaration of Human Rights* (UDHR) has influenced the worldwide development of laws, rules and regulations since it was adopted by the United Nations in 1948. Strictly speaking, the UDHR is not a legally binding document and, therefore, cannot be enforced. That said, the UDHR has acquired the status of "customary international law" because most states have come to treat it over the years as though it were. It has been a powerful instrument for the promotion and implementation of inalienable rights for all people, and it has left an abiding legacy for humankind.

Since the adoption of the Universal Declaration, there have been several developments, some of which are highlighted here. A major development has been the endorsement, ratification or adoption of the Universal Declaration by several psychology organizations. In 2008, for example, it was adopted by the Psychological Society of South Africa, and ratified by the Canadian Psychological Association. It was also adopted in 2008 by the Interamerican Society of Psychology, which took the extra step in 2009 to amend its Constitution to require from its membership compliance with the Universal Declaration. The International Association for Cross-Cultural Psychology adopted the Universal Declaration in 2010.

A "culture-sensitive" model has been developed to assist psychologists to apply the Universal Declaration to creating or reviewing a code of ethics (Gauthier, Pettifor, & Ferrero, 2010). The first step that is recommended is to consider the reasons to create a code of ethics (e.g., for whom is it intended, why is it needed,

how will it be used, are unique or cultural aspects to be addressed?). The second step is to consider what each of the four ethical principles means within the given culture and context. The third step is to define culture-specific standards or behaviors that are relevant to local objectives and also reflect proposed universal ethical principles. Throughout the process, it is strongly encouraged to consult those individuals whose work will be most affected by the code of ethics, as their input is invaluable to create a relevant document, and their support is invaluable in accepting the ultimate code of ethics.

National psychology organizations use the Universal Declaration (2008) to develop or revise codes of ethics. For example, the College of Psychologists of Guatemala used it to develop its very first code of ethics in 2008–2010 (Colegio de Psicológos de Guatemala, 2011). Actually, Guatemala was the first country in the world to use the Universal Declaration as a template to create an ethical code and the model proposed by Gauthier et al. (2010) as a guide to do so. The Australian Psychological Society used it to revise its code of ethics from 2005 to 2007 when the document was still in development. The International School Psychology Association consulted the Universal Declaration as part of revising its existing code in 2009–2011, and used it to inform the revision process (ISPA, 2011). It is presently used by the Canadian Psychological Association to review the *Canadian Code of Ethics for Psychologists*. An example of the influence of the Universal Declaration on the revised version of the Canadian Code can be found in the inclusion of the concept of "peoples" in the wording of one the first ethical principle presented in the Code which was changed from "Respect for the Dignity of Persons" to "Respect for the Dignity of Persons and Peoples" to reflect the importance of balancing respect for the individual versus the communal or collective.

Researchers and practitioners have used the Universal Declaration as a framework to discuss ethical issues from an international perspective and to offer recommendations of global value. In a recent article by Fitzgerald, Hunter, Hadjistavropoulos, and Koocher (2010), the authors examine ethical issues relating to the growing practice of internet-based psychotherapy through the lens of the Universal Declaration. On the basis of their review and discussion, they make recommendations intended to guide mental health practitioners who are considering involvement in the provision of internet-based services. Further, Psychologists around the world are faced daily with ethical questions and dilemmas. Sinclair (2012) has demonstrated how the Universal Declaration can be used as a resource in ethical decision making. Finally, the Universal Declaration has been the focus of book chapters in international handbooks (e.g., Gauthier & Pettifor, 2011, 2012) and a book chapter on internationalizing the professional ethics curriculum in the United States has dedicated several pages to the Universal Declaration (Leach & Gauthier, 2012). In summary, although the Universal Declaration (2008) is still new, it holds promise for extending psychological practice globally in ways that maintain the highest level of ethical practice, and that incorporates advocacy to eliminate misuse and abuse.

Future Global Directions of Ethics

This overview of ethics from a global perspective indicates that ethics documents have evolved considerably since the publication of the first code of ethics in psychology in 1953. They are becoming more international and more global. The Universal Declaration represents the latest expression of this movement and the largest international effort of psychologists to establish an explicit moral framework of ethical principles that are based on shared human values across cultures.

Another major development in ethics is the shifting emphasis from defining specific behaviors or standards as acceptable or not, to linking behaviors to an explicit moral framework. These changes were first observed in national codes of ethics in the late 1980s (Gauthier & Pettifor, 2011). While the value of combining statements of aspirational principles with general guidelines and enforceable standards for ethical behavior was being questioned in the United States (American Psychological Association, 1992, 2002a, 2002b), it was embraced in countries such as Canada (Canadian Psychological Association, 1986, 1991, 2000), Ireland (Psychological Society of Ireland, 1999), New Zealand (New Zealand Psychological Society, 2002), and Mexico (Sociedad Mexicana de Psicología, 2002, 2007). Universal principles and shared values are a prerequisite to link behavior to ethical principles internationally and globally. The Universal Declaration has built on the growing practice of defining a moral or philosophical foundation of universally shared principles, and has also been embraced in regional ethics documents (e.g., EFPA, 1995, 2005).

Language, meanings and themes evolve. For example, the definitions provided by the *Canadian Code of Ethics for Psychologists* on Respect for the Dignity of Persons since 1986 (CPA, 2000) and by the APA Ethics Code on Respect for People's Rights and Dignity since 1992 (APA, 2002a, 2002b) are similar in content, as they emphasize moral rights. Both codes also emphasize individual rights and well-being more than the collective good, which is common in Western societies. In the Universal Declaration, respect is described as "the most fundamental and universally found ethical principle" and is inclusive of non-Western and aboriginal beliefs:

> All human beings, as well as being individuals, are interdependent social beings that are born into, live in, and are a part of the history and ongoing evolution of their peoples. The different cultures, ethnicities, religions, histories, social structures and other such characteristics of peoples are integral to the identity of their members and give meaning to their lives. The continuity of peoples and cultures over time connects the peoples of today with the peoples of past generations and the need to nurture future generations. As such, respect for the dignity of persons includes moral consideration of and respect for the dignity of peoples.

The meaning of language will continue to be a challenge to the global acceptance and implementation of ethical principles shared across cultures. One of the lessons learned in working on the Universal Declaration was the meaning of language: differences in meaning across cultures are not always immediately visible and how to

cope with those differences is not always obvious (Gauthier et al., 2010). The importance of the meaning of language in a global society that lacks a global language cannot be overemphasized.

The current chapter also reveals that ethics documents tend to reflect contemporary concerns and that they evolve with changing world conditions. A huge concern after World War II was the discovery of the atrocities committed in Nazi Germany by qualified professionals, and the necessity to protect citizens from harm. The Nuremberg War Crime Trials led to new ethics standards to protect research participants from inhumane treatment. The United Nations (1948) adopted the *Universal Declaration of Human Rights* outlining for nations the rights and entitlements of all persons. In 1948, the APA began working on the development of the first code of ethics for psychologists that was adopted on a trial basis in 1952.

The Universal Declaration (2008) was developed in response to the rapid globalization of the world. We now live in a world where isolation is impossible, traditional national borders are rapidly fading, and many countries are increasingly becoming multicultural. On the one hand, technology has opened the possibilities for global peace and harmony, while on the other hand, it has increased the potential for universal suffering and destruction. The Universal Declaration was developed at a time when, for the sake of the future of our world, global consensus on what constitutes “good” was urgently needed.

The Universal Declaration (2008) reflects a concern that psychologists in a rapidly globalizing world need ethical guidelines that address global issues and can encompass working cooperatively across worldviews in ways that were not included in their professional training, their practice standards, their codes of ethics, or their past experiences. The larger context is the desire that the rapid globalization of life on the planet contributes to a better life for persons and peoples generally rather than contributes to increased suffering. While technology makes possible “one world”, the needs of people to maintain their cultural identities demand respect and, in addition, negate rules and prescriptions imposed from the outside on how they should conduct their lives. In this context, guidance from a moral framework that approaches universality leaves room for local initiative in defining culture-specific interpretations. In this respect, the Universal Declaration contributes to the process of recognizing what all peoples have in common and what is culture-specific.

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