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The Process of Professionalization: A Comparative Analysis of Clinical Psychology and Psychiatry

William E. Arens

ANALYSIS OF CLINICAL PSYCHOLOGY AND PSYCHIATRY - ARENS

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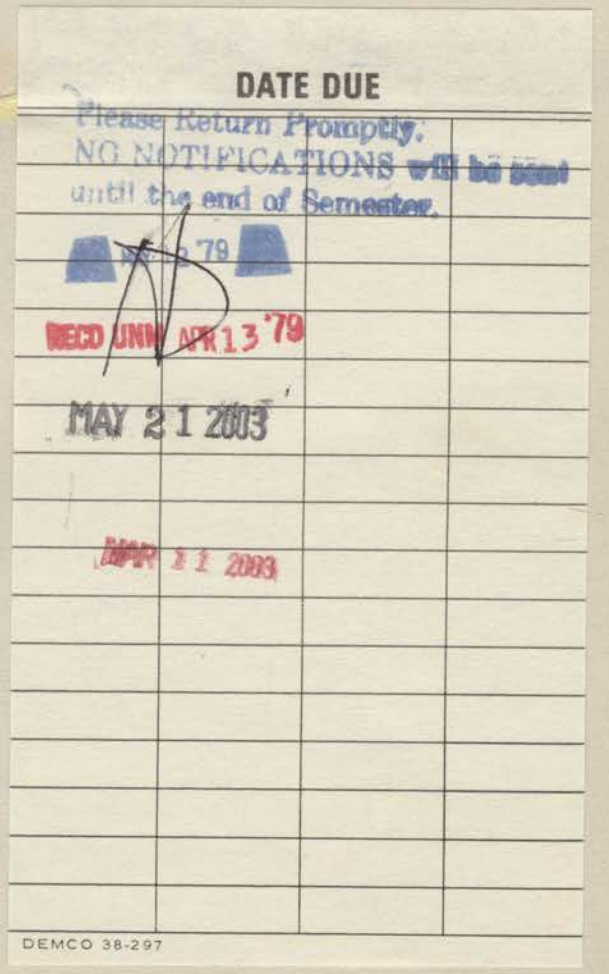

THE PROCESS OF PROFESSIONALIZATION:
A COMPARATIVE ANALYSIS OF CLINICAL PSYCHOLOGY AND PSYCHIATRY

By

William E. Arens

A Thesis

Submitted in Partial Fulfillment of the

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TABLE OF CONTENTS

CHAPTER I

INTRODUCTION

As a number of observers concerned with the sociology of work have pointed out, there has been a general tendency among occupational groups to strive for professional status. Historically this social phenomenon can be traced to Medieval Western Europe with the rise of church sponsored universities providing training primarily in theology, but also focusing on the study of medicine and law.[1] So long as the church maintained its predominance, the various fields for which the universities trained did not become clearly distinct. However, with the decline of the church's power in the 16th century, and as the culture of that period slowly shed its religious character, the professions of law and medicine began to emerge as independent associations.

During the next few centuries a number of others cautiously emerged, such as accountancy and architecture. With the opening of the 19th century and with the advent of the Industrial Revoluation, however, the quantity of recognized professions had increased markedly until it reached a point

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[1]A. M. Carr-Saunders and P. A. Wilson, "The Emergence of Professions," Men, Work, and Society, ed. Sigmund Nosow and William H. Form (New York: Basic Books, Inc., 1962), pp. 199-200.

where the actual functioning of complex societies depends so largely on the professions.

This is not to imply, however, that all occupations will eventually professionalize nor that all who have desired this distinction have been successful. The fact that only a small number of those attempting it have succeeded in having their claim to this exclusive distinction recognized by the relevant public prompts an analysis of the contingencies of the professionalization process.

I. DEFINITION OF THE PROBLEM

Studies in this area have usually emphasized the "natural history" of professionalism and in doing so convey the impression that the process is an invariant progression of events. Typical of such an approach is Wilensky's recent article which details in chronological order the steps taken by the established professions as well as those in process.[2] Included in this sequence is: (1) its establishment as a full-time occupation; (2) the founding of

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[2]Harold L. Wilensky, "The Professionalization of Everyone?" The American Journal of Sociology, 70(September, 1964), 143. Cf. A. M. Carr-Saunders and P. A. Wilson, The Professions (Oxford: Clarendon Press, 1933), Theodore Caplow, The Sociology of Work (Minneapolis: University of Minnesota Press, 1954), pp. 139-140, and Everett C. Hughes, Men and Their Work (Glencoe: The Free Press, 1958), pp. 133-137.

a training and then university school; (3) the organization of a professional association; (4) the enactment of a state license law; and finally, (5) the promulgation of an adhered-to code of ethical behavior. Although such an historical overview undoubtedly buttresses the assumption of a natural history, it also tends to obscure the amount of indecision and fluctuation in the course of action which in reality marks this process.

Through the framework provided by an historical analysis of the ideological and organizational strategy of an occupation engaged in the quest for professional recognition, it becomes possible to illustrate the problems and the possible responses inherent in each step of the process. Such an analytical approach to the type of social movement characterized by the professionalization process highlights the fact that a successful claim to professional status in the occupational world does not rest merely on the development of a number of concrete and static characteristics. Equally important is the ability of the leadership to make the correct choice in strategy from the number of possibilities presented and to implement them successfully through ideological and organizational means.

The claim of clinical psychology and the medical specialty of psychiatry to competence and functional autonomy in the treatment of mental illness is based on conflicting

ideological and organizational strategy. This suggests further that the professionalization process can be understood through an examination of the relationship between the body of applicable knowledge and the charting of strategy.

A review of past developments in the professionalization arena reveals that the majority of such movements have their genesis either in the attempt of an emerging specialty to secure for itself a position of acceptance and independence from an already established profession, or with the desire of a particular segment of an academic discipline to apply practically the knowledge provided by the established group. Accordingly, the latter's ideological justification for professional status rests on the previously existing body of generalized knowledge, while the former rests upon the claims that a newer, more distinctive approach to an existing problem is called for.

Such ideological claims require the professionalizing group to make a simultaneous organizational decision concerned with the structuring of formal relationships between itself and its parent body. Two obvious alternate courses of action are available: (1) it can remain in formal association with this already established organization; or (2) it can establish a new occupational association. Although the actual choices may be obvious, the possible results of either decision are fraught with hazards for the would-be professional segment.

The decision to establish an independent organization may well result in the loss of potential ideological support from the parent association. The alternative decision to remain a part of the already existing organization, however, could result in the inability of the professionalizing segment to have its interests adequately represented and acted upon. Consequently, regardless of actual choice in strategy decided upon, the professionalizing group must further structure this organizational relationship in the attempt to insure optimal support as it moves toward its goal.

In conclusion it is suggested then that although the specifics and emphasis may vary, the professionalization process can be more clearly understood at the generalized level of the structure of ideological and organizational strategy.

II. DEFINITION OF TERMS

Profession. Although there seems to be some disagreement in the pertinent literature as to what the crucial characteristic of a profession is, a number of distinctive qualities can be discerned. For the purposes of this report, then, a profession will be defined as an organized occupational group possessing the following characteristics: (1) an abstract systematic body of knowledge which is capable of being transmitted in theory as well as in practice through prolonged

specialized training; (2) an effective ethical code governing relations among colleagues as well as between practitioner and client; and (3) an ideology ideally based on a service orientation which the practitioners adhere to with more than lip service.[3] However, one further and most crucial distinction must be added: (4) the process of maintaining autonomy as an organized group. This includes the grant of a legal and public mandate to define standards of admission and competency for practitioners.[4]

Therefore, a profession may be defined as an occupational group which has succeeded in developing the aforementioned qualities and continues to maintain functional autonomy.

Professionalization. The conscious attempt by an organized occupational group which exhibits certain characteristics of a profession or is in the process of developing them to gain autonomy in the regulation of its affairs.

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[3]Harold L. Wilensky, "The Professionalization of Everyone?" The American Journal of Sociology, 70 (September, 1964), 140. Wilensky's recent article emphasizes the importance of this characteristic and states that if the client were not assured of the operation of this ideal, "he would be forced to approach the professional as he does a car dealer - demanding a specific result in a specific time and a quantity of restitution should mistakes be made."

[4]Everett Cherrington Hughes, Men and Their Work (Glencoe: The Free Press, 1958), p. 79.

III. METHOD OF INQUIRY

The existence of an ideological strategy based on theoretical knowledge and the analysis of its specific content has been undertaken through an examination of the official journal of the would-be professional associations as well as from other literature on the topic provided by each association's central office. Other sources, such as books and reports published under the auspices of the respective associations and material written independently by members of the association concerned with developments and problems in the area, will be reviewed as examples of strategy.

Although indications of incipient professionalization on the part of these groups can be observed from the beginning of the 20th century, the movements began in earnest at the close of World War II. Consequently, each volume of the official journals will be reviewed from the mid-forties until present as will be other pertinent material published during this period. The literature can be separated into three distinct categories: (1) articles submitted to the journals by members and books containing suggestions, analysis and criticism of the existing strategy and its consequences; (2) editorials and reprints of addresses delivered by officers of the association; and (3) official statements and positional papers of the association published in the journal for the

edification of its members.

Ideological claims by themselves, however, do not insure the achievement of professional status. Consequently, a more concrete plan of action or what may be defined as organizational strategy must be developed in the effort to implement these claims. In effect, the professionalizing group's organizational strategy is the attempt to institutionalize relationships with the relevant groups in the organizational role set.

This organizational plan of action can be viewed at two distinct levels of interaction: (1) from the standpoint of intra-group processes, or more specifically from the structure and function of relationships among members and segments within the occupational association; and (2) from the standpoint of inter-group processes or the relationship between the association and other relevant groups which must be taken into consideration with professionalization.

An analysis of intra-group processes is necessitated since the ideological claims of these two organizations are based on the application of an art developed by a larger group. Such claims inevitably commit the professionalizing segment to the establishment of associational relationships in the attempt to insure organizational as well as ideological support in their attempt to professionalize. Psychiatry and clinical psychology have tried to insure this support in a

contrasting manner. The former has attempted to institutionalize its relationships with the medical profession by maintaining as its occupational organization the independent American Psychiatric Association, while the latter has established itself as The Division of Clinical Psychology within the American Psychological Association. Although the strategy chosen by each is an attempt to minimize difficulties in achieving its goal, nevertheless, it presents certain other problems which must be resolved through organizational means.

Specifically, clinical psychology must insure that the professional interests of its division and those of allied specialties are being acted upon the the American Psychological Association as a whole. More concretely, it must see that the APA functions as a professional association rather than as a strictly academic community. On the other hand, psychiatry must establish itself in the eyes of the medical profession, i.e., the AMA, as a legitimate medical specialty worthy of recognition on that basis.

With clinical psychology, information on such internal conditions can be gathered through the analysis of structural changes within the American Psychological Association such as the establishment of committees and the content of their reports, the growth in size and influence of divisions representing specific interests whether professional or academic, and the background and orientation of the Association's

office holders. Data on such developments are regularly presented in the American Psychologist in the form of reports concerned with the official proceedings of the Association. Indications of a more unofficial nature are also available in the Journal of Clinical Psychology which is more readily concerned with the professionalizing problems of clinical psychology.

Similar information on psychiatry's structural relationship to the medical profession will be derived from an examination of the American Journal of Psychiatry and the Journal of the American Medical Association. The journal of the psychiatric association will be employed as an exemplification of this professionalizing segment's perception of an ideal organizational relationship as it strives for its goal. The official publication of the American Medical Association will serve to illustrate organized medicine's reaction to psychiatry's ideal structure as well as the actual relationship between the two.

On the level of inter-group processes, material from all the aforementioned sources in addition to other journals dealing with specific developments within this mental health complex will be analyzed. More specifically, strategic organizational responses of one to a course of action taken by the other and the establishment of inter-associational structures dealing with common problems will serve to

illustrate organizational strategy on the broader level of interaction.

The existence of organizational and ideological strategy based on theoretical knowledge and the resulting conditions provide further clues to the problems which must be resolved by either group if it is to achieve professional status. Although at present no clear cut prediction as to the outcome of this competitive process can be made, certain plausible alternatives present themselves. This competition for functional autonomy in the application of a technique is not unique to clinical psychology and psychiatry.

In the past a number of groups have sought the status of professionalism in other areas of public service. Descriptions and analyses of the various results of such movements have been recorded which may prove helpful in understanding this contemporary process. Consequently, through the integration of the information provided by a review of historical precedents with the analysis of this present example alternative conclusions to this process will be proposed.

CHAPTER II

THE PRESENT SETTING

Before an objective evaluation can be made of the problems of professionalization which confront clinical psychology and psychiatry, an examination of the historical roots of each discipline is necessitated. The discussion at this point will emphasize their growth as intellectual disciplines concerned with theoretical attempts toward the comprehension of human behavior as well as with certain historical developments within the mental health complex before well-organized attempts at professionalism were made. The analysis of the latter will be undertaken at a later point.

I. THE DEVELOPMENT OF CLINICAL PSYCHOLOGY AND PSYCHIATRY

The distinctiveness and history of each discipline as well as their basic theoretical inclinations have been traced to ancient Greece.[5] Psychiatry appears to have had its start with Hippocrates who saw epilepsy not of divine origin but as an organic disease affecting mental and

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[5]Albert Ellis, "The Roots of Psychology and Psychiatry," Psychology, Psychiatry, and the Public Interest, ed. Maurice H. Krout (Minneapolis: University of Minnesota Press, 1956), pp. 9-12.

physical functioning. At approximately the same time the psychological school had its emergence with Plato, Aristotle and others who began to speculate about the nature of man. As Ellis states: "From the start then medical psychiatry on the one hand and philosophy-psychology contributed to the scientific study of emotional processes, mental disorder, and psychotherapy."[6] Although the distinction between the two at some points appears vague, psychiatry continued to develop a medically oriented approach and until rather recently has emphasized the organic interpretation of mental illness, while psychology turned from philosophical speculation to an imitation of the "pure" sciences in the late 19th and 20th centuries.

Modern psychology began with an emphasis on the experimental method in the attempt to discover and study universal laws of behavior. When it became apparent that individual variations were the result of individual capabilities, psychology turned to the study of these differences. This led to the development of psychological testing and measurement with the work of such men as Galton, Cattell, Thorndike, Binet and Terman. Objective methods were emphasized and in general the clinical approach was minimized.[7]

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[6] Ibid., 10.

[7] Morris Krugman, "The Evolution of the Clinical Psychologist," The American Journal of Orthopsychiatry, 19 (January, 1949), 29-30.

With the establishment of a number of mental health clinics during the 1920's, the psychologists in the capacity of mental testers were called upon to help staff these centers. Consequently, they were exposed to a more clinical point of view. Although the psychologists assumed a passive role and low status in relation to the physicians with whom they worked, a certain amount of diffusion led to an emphasis on clinical techniques with the development of incisive projective tests, and the study of personality became as important as that of intelligence.[8] Testing was no longer mere measurement, but it now included diagnosis. As the horizons of psychology expanded so did its claim to legitimacy of function in relation to the therapeutic process.

While the "philosopher-psychologists" were addressing themselves to academic problems in scholarly settings, the forerunners of the present day psychiatrists were in the field attempting to apply what knowledge they had. During the 19th century the emphasis was on the strictly organic interpretation of mental illness. Treatment of the mentally ill in this era consisted of an accentuation of the existing tendency to introduce general medical and surgical methods

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[8]Starke R. Hathaway, "A Study of Human Behavior: The Clinical Psychologist," The American Psychologist, 13 (June, 1958), 258.

into psychiatry. Gradually, however, during the early 20th century a number of observers began to recognize that mental disorders must be regarded, at least in some instances, as abnormal reactions of individuals to their human needs and social settings.[9] As this recognition grew it brought with it new attitudes and methods of treatment.

This did not indicate, however, a basic shift in psychiatric techniques from the medical to the psychological approach, but rather a closer integration of both methods. It was an important step though, albeit unintentional, in determining the frame of reference for the present struggle over professional competence in the area of mental health.

It was not until World War II and its immediate aftermath that the areas of dispute were recognized and the lines of conflict between the two specialties were clearly drawn. The national emergency and manpower needs created by the United States' entry into the European conflict required the utilization of both psychologists and psychiatrists in large numbers. For the psychologists this provided an excellent opportunity to engage in clinical work even if previous training had left them unprepared for such activity. An analysis of duties performed and preferred by psychologists

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[9]William Malamud, "The History of Psychiatric Therapies," One Hundred Years of American Psychiatry, ed. J. K. Hall, Gregory Zilboorg and Henry Alden Bunker (New York: Columbia University Press, 1944), pp. 297-298.

while in the service indicated a tremendous interest in the clinical field. Those who desired to return to school after discharge also strongly endorsed the idea of a greater emphasis on applied clinical psychology in training programs.[10] A further study found that three times as many psychologists were engaged in clinical work after the war as were before.[11]

The experiences of psychiatry during this period closely paralleled those of clinical psychology although with some variation. The needs of the military machine during World War II drew psychiatry more and more out of the realm of individual psychopathology and into what one psychiatrist defined as "the currents of social, educational, and political activities."[12] He continues:

> . . . the old idea of seeing a psychiatrist only for insanity is very gradually being forgotten. Psychiatrists will be called upon to deal with problems which have hitherto been regarded as minor behavior deviations . . . There seems to be no doubt that from now on psychiatrists will be sought in increasing degree for help to

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[10]Steuart Henderson Britt and Jane D. Morgan, "Military Psychologists in World War II," The American Psychologist, (1946), 437.

[11]T. G. Andrews and M. Dreese, "Military Utilization of Psychologists During World War II," The American Psychologist, 3(1948), 533.

[12]Robert P. Kemble, "Do We Need Schools for Psychiatry?" American Journal of Orthopsychiatry, 15 (October, 1945), 734.

> individuals, and will also be invited to contribute technical advice toward the intellectual and moral vigor of our citizency.[13]

An analysis of the developments which took place during and after the war indicates then that both groups began to shift their focus of attention toward an area which had previously been disregarded. For psychiatry it was a movement toward the treatment of slight mental disorders in private clinical settings rather than solely the treatment of psychoses in mental hospitals; and for psychology it was a growth of interest in the application of clinical procedures to the same problems. As each attempted to professionalize by laying claim to legitimate professional activity in this area, it was not surprising as William Goode has pointed out that cries of "encroachment" and "charlatanism" were exchanged.[14]

Both psychologists and psychiatrists function in clinical settings today largely as a result of what might be called an historical accident when their distinctive histories and traditional subject matter, emphasis and training are considered.[15] In essence each developed largely

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[13]Ibid., 734.

[14]William J. Goode, "Encroachment, Charlatanism, and the Emerging Profession: Psychology, Sociology, and Medicine," American Sociological Review, 25(December, 1960), 902.

[15]Ellis, op. cit., p. 13.

independently of the other, except for some degree of intellectual borrowing, until suddenly they faced each other over the clinician's couch. However, it cannot be expected that the outcome of this situation will be an accident, for professionalization is a conscious and, in this case, a well-organized movement.

II. THE MENTAL HEALTH COMPLEX

In essence the professionalization process is the attempt by an occupational group to establish itself as the final arbiter in all matters concerned with the application of an art. The recognition of this claim is not immediately granted, and the achievement of this position in all instances involves a struggle between the aspiring group and other organizations in society. If the occupation endeavors to professionalize by attempting to solve a problem which previously had been disregarded, the conflict may be minimized. However, if the area has already been claimed or is in the process of being claimed by another specialty, the friction is naturally compounded, and such is the case in the area of mental health.

The psychotherapeutic complex may be envisioned then as an area of competing institutions. The frontiers between them are neither clearly marked nor definitely assigned. The situation could best be defined as hazy and confused even

though the battle lines are obvious. Psychiatry and clinical psychology are sharing tasks which each is seeking to monopolize as part of its own professionalizing drive. Both medical and nonmedical institutions are responding to the same contingencies of community health.[16]

The lack of normative standards can be discerned in a number of distinct spheres. However, at the inter-organizational level of interaction the basic issues involved are clearly perceived. It is recognized that no existing legal statutes define with precision the type of mental afflictions which either clinical psychology or psychiatry may alone treat. Although psychiatry as a medical specialty may claim this prerogative legally, its position in untenable.[17]

Both clinical psychology and psychiatry, therefore, are aware that certain mutually beneficial steps must be taken before the situation can be stabilized. First, the problem of collaboration and supervision between the two in research, in graduate and professional education, in psychotherapy, and in the practice of the respective specialties must be resolved. Second, both groups recognize that there

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[16]Harvey L. Smith, "The Value Context of Psychology," The American Psychologist, 9(September, 1954), 535.

[17]Anonymous, "Regulation of Psychological Counseling and Psychotherapy," Columbia Law Review, 51(April, 1951), 478.

is a public demand and community need that must be met. Third, it is felt that some machinery must be established for the interchange of ethical complaints in a formal manner. Finally, these conditions must be acted on as soon as possible in order to avoid a continued public quarrel which would be detrimental to both groups.[18]

A further indication of the unstable condition of the mental health complex was determined by Schatsman and Bucher's study of the division of labor among therapists in a mental hospital.[19] In the attempt to study the organization of treatment and the division of labor among clinical psychologists, psychiatrists and social workers in a hospital ward, they found that thinking in terms of social roles would not be very useful since it would require considerable consensus among participants about role expectations and a greater amount of role stability than was apparent. Similarly, viewing the situation as one of social disorganization would not be fruitful since no reasonably stable organization had existed in the first place. Consequently, they were forced to observe the situation within a framework of evolving social

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[18]The American Psychiatric Association and the American Psychological Association, "Joint Report on Relations Between Psychology and Psychiatry," The American Psychologist, 15 (March, 1960), 199.

[19]Leonard Schatzman and Rue Bucher, "Negotiating a Division of Labor Among Professionals in the State Mental Hospital," Psychiatry, 27(August, 1964), 266-277.

forms whose details and rules were collectively vague and uncertain since few proven models existed.

As could be expected, primarily because of the fact that a need for the service was apparent, a division of labor was worked out, but its form varied from ward to ward. In one ward the psychologist was permitted to engage in therapy without supervision, while in another supervision by a psychiatrist was required, and in a third the psychologist was not allowed to assume this role at all and devoted most of his time to testing. Such fluctuation from ward to ward existed in relation to every role—from physician to nurse. Further, a readjustment in expectations and responsibilities was required with the exit of an existing participant and the entrance of a new one.[20]

Turning from an examination of the flux which exists among the organizations and individuals directly involved with the application of techniques and focusing on the public's knowledge about mental illness and treatment as an indication of the degree of institutionalization, the situation takes on even less stability. One study conducted to describe the popular notions about mental illness and its treatment had difficulty for just this

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[20] Ibid., 270-275.

reason.[21] If the replies to the question are to be meaningful when interpreted for a large number of interviews, then the question itself must be understood approximately the same way by everyone asked. In inquiring about the public's conception of mental health this condition could not be met. Consequently, the researchers had to adopt the technique of asking each individual who was interviewed to state what he meant by mental illness, and then interpret his answers to all other questions in the light of that statement.

The study determined that most people have great difficulty in merely verbalizing a concept of mental illness or of its remedies. According to the results, at least half equated mental illness with psychosis but used the terms "insane," "crazy" or "out of their head." Emphasis in describing the mentally ill was put on violent behavior, incomprehensible talk, and delusions or hallucinations. Other behavioral maladjustments, such as neurosis, were not considered to be mental illness.[22] The study further discovered that the prevailing view of

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[21]The American Psychiatric Association, Psychiatry the Press and the Public, Report of a Conference on Special Problems of Communicating Psychiatric Subject Matter to the Public, Edited by Wilfred Bloomberg, et al. (Washington: The American Psychiatric Association, 1956), pp. 1-11.

[22]Ibid., 2.

treatment held by the public involves its perception as merely concerned with an expression of understanding, sympathy and a great deal of patience; hence what the psychiatrist or clinical psychologist does for a mentally disturbed person is thought to be no different from what anyone else with the time and interest might do.[23] The implication these conceptions may have on the ability to professionalize by either group will be discussed in Chapter V.

III. SUMMARY

The situation then is that of two groups evolving along separate lines simultaneously attempting to implement their professional goal around the treatment of the emotionally disturbed. Correspondingly, this institutional area exhibits a high degree of instability at all levels of interaction and with all groups concerned. The resolution of this condition is the goal of both groups through the achievement of professional status and the concurrent ability to establish what they would consider to be the appropriate role-relationships and normative standards. In spite of the fact that a great deal of instability may exist at this point, each group has

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[23] Ibid., 5.

developed an ideal situation at least from its own standpoint. The attempt by a professionalizing occupation to realize this ideal state of affairs is undertaken through the employment of ideological and organizational strategies, an analysis of which will be made in the following chapters.

CHAPTER III

IDEOLOGICAL STRATEGY

The distinctive characteristic of the profession is the exercise of a public and legal mandate to function as an autonomous unit. As would be expected, this privilege is not always granted, and if granted it is with some reluctance for it is in effect the delegation of official power to a nonofficial group.[24] The decision by the state to recognize an occupational group as legally autonomous in the regulation of its affairs is prompted by the realization that existing organs of government are incompetent to make valid judgments in this area of specialization. A further implication of this action is the recognition that the skills applied by the practitioner are particularly vital in relation to public interest. The general strategy of the professionalizing group, then, is to convince the public and its legislative representatives that the service it performs is vital, and further, esoteric to the extent of requiring regulation by the profession itself.

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[24]Anonymous, "Delegation of Governmental Power to Private Groups," Columbia Law Review, 32(January, 1932), 80.

I. CLINICAL PSYCHOLOGY AND THE CLAIM TO PROFESSIONALISM

Clinical psychology's ideological rationale for professional status rests on three basic claims: (1) the body of knowledge and technique developed by the discipline of psychology is best suited for the treatment of mental illness; (2) the demand for this vital service far exceeds the ability of existing specialties to meet it; and (3) professional recognition or functional autonomy insured by legislation is in the public interest.

As mentioned, while clinical psychology was evolving within the confines of academic organizations, the M.D.'s concerned with the treatment of mental illness were attempting to solve the problem with the means available. Consequently, with the emergence of clinical psychology from its academic roots as an applied specialty, it found the field in the process of being claimed by a medically oriented group. As an organized body clinical psychology's problem has been to insure a place for themselves in this complex of competing groups. They have attempted to do so through the claim to professional recognition based partly on their ability to provide a specialized service.

In essence psychology's ideological position revolves around the desire to define mental illness, or at least certain aspects of it, in such a way as to insure that the

service it provides adequately meets this problem. This means that maladjustment is defined at least partly as non-organic in origin and consequence, and, therefore, the non-medical approach to its treatment is most valid in such instances. From this starting point it is argued that since clinical psychology's emphasis and training have traditionally been of a nonmedical nature, it is best able to treat the problem. Robert Lindner, a highly respected nonmedical therapist, in addressing himself to this problem stated:

> By its very definition and sense psychotherapy excludes everything elemental to the practice of medicine except its concern for those to whom it is applied . . . The scientific well from which psychotherapy takes its beginnings and draws its sustenance has always been, and must always be, psychology. This remains the inclusive discipline, referential frame and source bed for all that concerns man in his totality, and who would minister to man . . . must be a psychologist first and last.[25]

Lindner also adds that not only is clinical psychology's approach valid, but that the traditional emphasis of medicine on the treatment of mental illness is invalid and further that the orientation of the medical clinician is generally

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[25]Robert M. Lindner, "Who Shall Practice Psychotherapy," Psychology, Psychiatry and the Public Interest, ed. Maurice H. Krout (Minneapolis: University of Minnesota Press, 1956), pp. 150-151.

unsuitable to the problems faced daily by the therapist.[26]

The second aspect of clinical psychology's ideological strategy is based on the fact that World War II and its immediate aftermath highlighted the discrepancy between the need for psychotherapy and the capacity of the medical profession to meet it. And since clinical psychologists were able in these circumstances to demonstrate their effectiveness as therapists, the training of large numbers of nonmedical psychotherapists seemed a practical answer to a pressing problem.

Further, the continuing and increasing demand for psychotherapy, it is stated, is a result of a broad cultural phenomenon which perceives this service as a "good" or in other words that clinical psychology merely responds to the emergence of a new cultural value. It is claimed that nonmedical psychotherapy is being sought by people who do not think of themselves as ill, but rather wish to avail themselves of something they believe to be good for them. In these instances it is offered by individuals who do not consider that they are treating disease, but rather that they are aiding the realization of certain ethical values.[27]

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[26]Ibid., 148-149.

[27]Nevitt Sanford, "Psychotherapy and the American Public," Psychology, Psychiatry, and the Public Interest, ed. Maurice H. Krout (Minneapolis: University of Minnesota Press, 1956), pp. 5-6.

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The second source of clinical psychologists' ideological strength is based on the fact [illegible] World War II and its immediate aftermath highlighted the discrepancy between the need for psychotherapy and the capacity of the medical profession to meet it. [illegible] clinical psychologists were able to seize the opportunities to demonstrate their effectiveness as therapists, the training of large numbers of nonmedical psychotherapists [illegible] a practical answer to a pressing problem.

Further, the continuing and increasing demand for psychotherapy, it is asserted, is a result of a broad cultural phenomenon which perceived illness as a "good," or in other words that clinical psychology merely responds to the emergence of a new cultural value. Sanford claimed that nonmedical psychotherapy in fact served all people who do not think of themselves as ill, but rather want to avail themselves of something they believe to be good for them. In these instances it is offered by professionals who do not consider that they are treating illness, but rather that they are aiding the realization of certain ethical values.[21]

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[20]Ibid., 177-178.

[21]Nevitt Sanford, "Psychotherapy and the American Public," Psychology, Psychiatry, and the Public Interest, ed. Maurice H. Krout (Minneapolis: University of Minnesota Press, 1956), pp. 266.

Accordingly, any organized effort by the medical profession to inhibit this process is reactionary and not in the public interest.[28]

This third aspect of ideological strategy, the question of public interest, is given special attention by the psychologists as it is with any professionalizing group. The movement to secure professional status through legal recognition undoubtedly owes its origins and motivation to two contradictory ideas. It is initiated from within by a group that wishes to secure special consideration in the occupational structure while the reason given for this recognition is urged in the name of the public welfare. Consequently, it is claimed that the public and not the practitioners will benefit with the achievement of legal professional status by applied clinical psychology for then protection against the incompetent and unethical will be assured.[29] Taking this a step further one psychologist has claimed that whenever a service is in great demand, the government has an obligation to the public to see that it

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[28]Lindner, op. cit., p. 149.

[29]Robert S. Daniel and C. M. Louttit, Professional Problems in Psychology (New York: Prentice-Hall, Inc., 1953 p. 287; Jean Walker MacFarlane, "Inter-Professional Relations and Collaboration with Medicine and Other Related Fields," The American Psychologist, 5(April, 1950), pp. 112-114; and Dael Wolfle, "Legal Control of Psychological Practice," The American Psychologist, 5(December, 1950), pp. 652-653.

is protected from unscrupulous practitioners by granting the occupational association the privilege to regulate the application of the technique.[30]

An analysis of this ideological approach to the problem of professionalization yields some interesting points. The most striking aspect is its logical sequence; that is, of course, if one accepts the initial assumption concerned with the validity of clinical psychology's technique. If this point is granted and the psychologists act as if it were irrefutable, then little fault can be found with the following claims that professionalism is obviously the next step when the public's welfare is considered.

Also worth noting is their assumption that they are merely responding to the emergence of a new cultural value. The interesting element here is that clinical psychology as part of the general mental health movement takes no responsibility for the development of this new attitude on the public's part. Although it cannot be stated categorically that it has not, there is ample reason to doubt that such a value would suddenly have appeared if not for the insistence by all would-be professional mental health groups that the

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[30]Karl F. Heiser, "The Need for Legislation and the Complexities of the Problem," The American Psychologist, 5(April, 1950), p. 104.

is protected from unwarranted practitioners by granting the occupational association the privilege to regulate the application of the technique.[30]

An analysis of this functional approach to the problem of professionalization yields some interesting points. The most striking aspect is the logical tautology that is, of course, if one accepts the [illegible] assumption concerned with the validity of [illegible] technique. If this point is granted and the psychologists act as if it were irrefutable, then little fault can be found with the following [illegible] that professionalization is obviously the next step when [illegible] values are considered.

Also worth noting is their [illegible] that [illegible] merely responding to the [illegible] of a [illegible] value. The interesting element here is [illegible] as part of the general mental health movement takes no responsibility for the development of this value within the public's [illegible]. Although [illegible] that it has not, there is ample reason to doubt that such a value would certainly have appeared if not for the [illegible] by all would-be professional mental health groups that the

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[30] Carl R. Rogers, "The Road for Legislation and the Complexities of the Problem," The American Psychologist, 5(April, 1950), p. 204.

service they provide is valuable. The question is whether or not clinical psychology is responding to a need which itself has had a hand in creating and one which no single group can presently meet. However, such an approach would not be in the best interests of professionalization for it would obviate the question of public welfare.

The ingenuity of this strategy is also evident when the possible responses left open to psychiatry are taken into consideration. If the medical group were to take exception to psychology's claim that it is meeting an obvious human need which must be protected from exploitation by the unethical practitioner, then it is placed in a rather poor light and as has been noted is exposed to charges of acting with little regard for public welfare. On the other hand, if it chooses to attack the validity of nonmedical techniques of the "psychological" approach then it only succeeds in depreciating a theoretical assumption which it also employs.

At first glance this might appear to present psychiatry with an inescapable dilemma. However, if this were indeed the case then this conflict, which has been continually raging for over twenty years, would have been resolved. The fact that it has not prompts an examination of psychiatry's response and its overall ideological strategy.

service they provide is valuable. The question is whether or not clinical psychology, in emphasizing the [illegible] which itself has had a need in [illegible] and one which [illegible] single group cannot properly [illegible], would not be in the best interests of professionalization for it would avoid the question of public welfare.

The integrity of this strategy is also evident when the possible responses left open to psychiatry are taken into consideration. If the medical group were to take exception to psychology's claim that it is meeting an obvious human need which must be protected from exploitation by the medical practitioners, then it is placed in a rather poor light and it has been cast in a role [illegible] of acting with little regard for public welfare. On the other hand, if it attempts to attack the validity of the clinical techniques of the "psychological" approach then it only succeeds in depreciating a therapeutic approach which it also employs.

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II. PSYCHIATRY AND THE MEDICAL CLAIM TO PROFESSIONALISM

Since psychiatry had already laid tentative claims to professional status before the emergence of clinical psychology, psychiatry's ideological emphasis is a rebuttal of its rival's claims. Its ideological strategy states: (1) the body of knowledge and techniques developed by medicine and its psychiatric branch are more suitable to the treatment of mental illness than a strictly "psychological" approach; (2) a need exists which cannot be met by psychiatry alone but that this need must be met with the adequate safeguards which psychiatry provides; and finally, disregarding the more rational approach it states that (3) the treatment of the sick whether physical or mental has always been the responsibility of medicine.

The first point in its ideological strategy is similar to that of clinical psychology in that it attempts to define mental illness and therapy in such a way that psychiatry adequately fits the definition. The definition of the situation varies from its competitors in that it takes into account more than purely nonorganic factors and consequently enables psychiatry to attack psychology's ideological claims without actually attacking the psychological technique. Therefore, it resolves the aforementioned basic ideological dilemma. In essence

psychiatry with the backing of organized medicine fails to draw any clear cut distinction between physical and mental factors in the treatment of mental illness. An American Medical Association Committee concerned with this problem stated:

> Even in cases in which treatment may be exclusively psychotherapeutic, or if preferred psychological, there are other than psychological aspects to be considered in the total treatment situation. Diagnosis which concerns a process of examination and evaluation derived from a course of medical education, involves the whole individual, not his psyche alone.[31]

This statement implies by its definition of illness that the training and competence of the nonmedical therapist is inadequate when the complexities of the situation are taken into consideration. On the other hand, the medical therapist is ideally suited to handle this same situation. A statement issued six years later is more specific on this subject and rather than implying definitions of mental illness and therapy it states them clearly:

> The systematic application of the methods of psychological medicine to the treatment of illness, particularly as these methods involve gaining an understanding of the emotional state of the patient and aiding him to understand himself is called

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[31]Francis J. Gerty, J. W. Holloway and R. P. McKay, "Licensure or Certification of Clinical Psychologists," The Journal of the American Medical Association, 148 (January 26, 1952), 272.

> psychotherapy. This special form of medical treatment may be highly developed, but it remains simply one of the possible methods of treatment to be selected for use according to medical criteria for use when it is indicated. Psychotherapy is a form of medical treatment and does not form the basis for a separate profession . . .[32]

This ideological approach and its indirect criticism of the validity of clinical psychology's orientation has a twofold purpose. First, it does not discard the value of nonmedical treatment per se and yet it considers such an approach to all problems a definite handicap, one which psychiatry as a medical specialty is able to overcome.

The omnipotent assumption of the psychiatric approach in comparison to the psychological one allows the medical group to attack the problem of public welfare in a more favorable light. Psychiatry's strategy as evinced by the aforementioned reports and others implies that the independent operation of psychologists may lead to errors in the diagnosis and treatment of mental illness because of the failure to recognize physical disorders which may be the basis of maladjustment or the inability to treat organic reactions of functional disorders. Therefore, if the welfare of the patient and

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[32]American Medical Association, American Psychiatric Association and American Psychoanalytic Association, "Resolution on Relations of Medicine and Psychology," The American Journal of Psychiatry, 114(February, 1958), 761. (Italics mine)

> psychotherapy. This essential [illegible] of medical treatment may be [illegible] shared, but it remains [illegible] medical responsibility. [illegible] methods of treatment to be selected [illegible] used according to medical [illegible] not when it is inadequate. [illegible] of medical treatment [illegible] the basis for a separate profession . . . .[2]

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The conceptual assumption of the psychiatric approach in comparison to the psychological one allows the medical group to attack the problem of public welfare in a more favorable light. Psychiatry's strategy as outlined by the aforementioned reports and others implies that the independent operation of psychologists may lead to errors in the diagnosis and treatment of mental illness because of the inability to recognize physical disorders which may be the basis of certain emotional [illegible] or the inability to treat organic reactions of functional disorders. Therefore, [illegible] the welfare of the patient and [illegible]

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[2]American Medical Association, American Psychiatric Association and the American Psychoanalytic Association, "Resolution on Relations of Medicine and Psychology," The American Journal of Psychiatry, [illegible] (italics mine).

the public in general is to be protected, all therapy must be carried out in a setting where "adequate psychiatric safeguards are provided."[33]

Such an approach also neatly answers psychology's claim that psychiatry cannot meet the demand for services which has been made by the public. Implied in the statement that all therapy must be carried out under adequate supervision is that there is a place for clinical psychology in the therapeutic setting as long as the superior value of the all-encompassing psychiatric technique is recognized. Organized psychiatry makes its position clearer by calling on the psychologists to join with the psychiatrists in the treatment of mental illness by functioning primarily as diagnosticians while their medical counterparts handle the treatment aspect. It is stated that in some cases and under these conditions the psychologists might also be allowed to "do therapy."[34]

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[33]Group for the Advancement of Psychiatry, "The Relations of Clinical Psychology to Psychiatry," The American Journal of Orthopsychiatry, 20(April, 1950), 351.

[34]Ibid., 353; Walter E. Barton, "Psychiatry in Transition," The American Journal of Psychiatry, 119(July, 1962), 4 (presidential address delivered at the 118 Annual Meeting of the American Psychiatric Association, at Toronto, Canada, May 7-11, 1962); and George Yacorzynaki, "The Functions of Psychology in a Medical Situation," Psychology, Psychiatry, and the Public Interest, ed. Maurice H. Krout (Minneapolis: University of Minnesota Press, 1956), p. 60.

The analysis of the first two aspects of psychiatry's ideological strategy illustrates its negative orientation since it serves primarily as a rebuttal to psychology's professional claims. This is not to convey the impresseion that it is an unsuccessful one for it provides adequate answers to the problems presented. However, there is one further element which represents an entirely different and positive claim.

The most impressive quality of the comparative strategy thus far has been the emphasis on rationality in the form of attempting to prove a point on the basis of sound argument. However, it appears that at a point psychiatry recognized that controversies are not always resolved on this basis alone and included an appeal to sacred tradition. This appeal takes shape in the statement that the medically trained have always treated the sick. The American Psychiatric Association's Committee on Clinical Psychology exemplifies this approach in a report which stated:

> In adopting this position, the committee has not believed that it has stated a new principle, but rather that it was reaffirming an attitude recognized since time immemorial that, in the treatment of the sick, psychotherapy is an essential part of the physicians' armamentorium.[35]

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[35]Paul E. Huston, "The Work of the Committee on Clinical Psychology," The American Journal of Psychiatry,

CHAPTER IV

ORGANIZATIONAL STRATEGY

Although the importance of ideology in the process cannot be overemphasized, the picture would not be complete without taking into account the organizational strategy, or the actual steps which have been taken or planned by each group. The emphasis at this point shifts from what is being claimed to what has been accomplished and what is hoped to be accomplished.

This aspect of professionalism prompts an analysis of the organizational strategy which has been developed and its success or failure as the professionalizing group interacts with external agencies. Such groups include the public, their legislative representatives and organized medicine, including psychiatry. Organizational strategy, however, is not solely concerned with the structuring of external relations, but must also take into account the institutionalization of internal arrangements. Therefore, an analysis of the internal affairs of the occupational associations, as vehicles of professionalization, will also be undertaken.

This approach is necessitated because (1) it cannot be assumed that the goal of professionalism is desired by all members of an occupation; nor (2) can it be taken for

What is most interesting about this statement is its failure to define just what psychotherapy is; whether or not this has been a successful arrangement; and its disregard for a defense of this situation. What is important from the Committee's viewpoint, however, is that it has always been so. Illogical though it may be, it is also based on the solid fact that the public is more disposed to seek advice and help from an M.D. than from any other mental health therapist.[36] The psychiatrist's problem, however, is to convince the public that he too is an M.D.

III. SUMMARY

The ideological strategy of each group, then, is to convince the public as well as other relevant groups within this organizational role-set that it is the most qualified to treat the mentally ill. Primarily this process involves the attempt to define this phenomenon and its treatment with reference to the training which the specialty provides and the technique it employs. Other elements such as the public welfare and appeals to tradition also enter the

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109(April, 1953), 791. The American Psychiatric Association's bulletin, Relations of Medicine and Psychology (Washington: American Psychiatric Association, 1954), also exemplifies this approach.

[36]Jum C. Nunnally, Popular Conceptions of Mental Health (New York: Holt, Rinehart and Winston, Inc., 1961), p. 64.

picture. Clinical psychology has attempted to achieve its professional goal through the claim that a unique approach to the problem of mental illness is called for while psychiatry has emphasized its relationship to medicine and the established clinical procedures.

The consequence of such an arrangement, however, does more than tie the professionalizing group to a larger segment ideologically and intellectually. It also commits itself to the establishment of organizational arrangements with the parent body as the specialty moves toward professionalism. The steps clinical psychology and psychiatry have taken during this process and the relationships which have been established with the parent associations in the attempt to insure organizational support will be discussed in the following chapter.

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This approach is necessitated because (1) it cannot be assumed that the goal of professionalism is desired by all members of an occupation; nor (2) can it be taken for

granted that the means of achieving it are unanimously accepted; and finally (3) the process necessitates the delegation of organizational authority to members of the association who make decisions affecting the occupation as a whole. Consequently, the internal analysis of the association of a professionalizing group must assume the existence of competing factions.

The following discussion will therefore center on a comparative examination of both the intra- and inter-associational organizational strategy of these two groups. The analysis will delineate how each group has attempted to solve problems common to both as well as the unique ones each has had to face. Such an approach will highlight the extent of fluctuation in their courses and the degree of friction which accompanies this process.

I. CLINICAL PSYCHOLOGY

At the present time the clinical psychologists function principally as a division of the American Psychological Association. Accordingly, as a group it is bound in formal association with what can be recognized as two distinct other groups. First, clinical psychology is only one area of the many fields of applied psychology and second, it is just one division of a score of other divisions both applied and scientific. Taking into consideration the diverse

character of this association and especially the obvious existence of an applied-academic bipolarity, the strains in this relationship are obvious.[37] As one psychologist stated in the official journal of the association: "Academic and applied or professional psychology are not identical. The goals and means of each are different."[38] Although the author is addressing himself to the problem of evolving different methods of training for each group, his discussion focuses on one of the major differences of orientation in the world of psychology. Another article which strikes more clearly at the core of this problem states that "the amazing support which the APA is according psychology as a profession has not only led to the neglect of scientific interests but contains in it forces positively inimical to its growth as a science."[39]

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[37]Academic psychology is defined as a scientific discipline concerned with theory and method without regard to applicability. Research is designed to investigate problems without any concern as to whether the results will be socially useful. Professional psychology is defined as the application and development of theory and methods of specific immediate problems of the individual and society. Professional research is concerned with concrete immediate problems, not with broad theoretical issues. Robert C. Tryon, "Psychology in Flux: The Academic-Professional Bipolarity," The American Psychologist, 18(March, 1963), 135.

[38]David A. Rodgers, "In Favor of Separation of Academic and Professional Training," The American Psychologist, 19(August, 1964), 679.

[39]Saul Rosenzweig, "Imbalance in Clinical Psychology," The American Psychologist, 5(December, 1950), 679.

An examination of the previous strategy employed by the applied clinical psychologists might shed some light on why they have chosen this present path with its unique problems.

In previous years the clinical psychologists had chosen an alternate organizational strategy based on the formation of a separate association. The first such movement was initiated in 1917 when forty-five men and women holding doctorates in psychology and engaging in the practice of applied psychology in the United States met in Pittsburgh to establish the American Association of Clinical Psychology.[40] The objects of this association were:

> . . . (1) to promote an esprit de corps among professional psychologists, (2) to provide media for the communication of ideas, (3) to aid in the establishing of definite standards of professional fitness for work in clinical psychology, and (4) to encourage research in problems relating to mental hygiene and objective education.[41]

This organization remained in existence for only two years and became defunct in 1919 with the establishment of a Clinical Division by the American Psychological Association.

However, the desire to develop a separate association was not defunct and in 1921 the clinical psychologists joined with other applied specialties to organize the New York State Association of Consulting Psychologists. In 1930, the

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[40] J. P. Symonds, "Toward Unity," Journal of Consulting Psychology (January-February, 1937), 23.

[41] Ibid., 23.

association was reorganized and the name changed to the Association of Consulting Psychologists. The scope of the Association was widened to include all professional and applied interests. By 1935, fifteen other state and regional associations had been formed. This prompted the formation of a national committee of representatives drawn from the various regional groups in 1936 for the purpose of drawing up plans for a national association of professional psychologists. After deliberations the committee agreed upon the formation of a national organization and submitted a number of proposals concerned with the aims of this association. Among the more interesting suggestions were:

> That large specialized groups in application, such as in industry and clinics, should have professional autonomy in the national society . . .
>
> That licensing of applied psychologists for special professional work . . . should be achieved through the channels of government . . .
>
> That the proposed national society of applied psychology should coordinate its development as a professional association with the American Psychological Association, Inc., which is organized as a scientific society, so that their mutual interests may strengthen psychology as a whole.[42]

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[42]Robert G. Bernreuter, "The Proposed American Association for Applied and Professional Psychologists," Journal of Consulting Psychology, (January-February, 1937), 14-15. (Italics mine)

association was reorganized [illegible] it [illegible] of the Association of Consulting Psychologists. The [illegible] was Association was widened to include all professional and applied [illegible], and [illegible] associations had been formed. This prompted the formation of a national committee of representatives from the various regional groups in 1936 for the purpose of drawing up plans for a national association of professional psychologists. After deliberation the committee agreed upon the formation of a national organization and submitted a number of proposals concerned with the aims of such association. Among the more important suggestions were:

> That large specialized groups in application, such as industry and guidance, should have professional autonomy in the national society . . . ;
>
> that [illegible] of applied psychologists for special professional work . . . should be enhanced through the standards of accredita-tion . . . ;
>
> That the proposed national society of applied psychology should work for the development of a professional association with the American Psychological Association, [illegible], organized as [illegible] society [illegible] the whole.[2]

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[2][illegible], "The Proposed National Association for Applied Psychology," Journal of Consulting Psychology, I (January-February, 1937), 14-16.

Subsequently on September 1, 1937, the American Association of Applied Psychology was formed by a merger of the Association of Consulting Psychologists with the clinical section of the APA.[43] Although this organization maintained ties with the APA, it is obvious that its members were aware of a distinction between their field and the more scientific orientation of the APA. Consequently, they were of the opinion that their problems and goals deserved a special emphasis which was not being provided by the parent group. Although exact figures are not available, it is likely that the applied fields were a distinct minority in the APA. Accordingly, for all practical purposes, their goals could only be achieved through a separate association.

The question to be asked at this point, then, is why did the clinicians and the other specialties decide to rejoin their parent association? The answer lies in the fact that since 1937, and especially during the war years, the applied fields have undergone tremendous expansion in terms of importance and numbers. Therefore, re-establishing formal relations with the APA did not place them in a subordinate position in relation to numbers of means of access to the policy-making positions.

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[43]Percival M. Symonds, "New Notes," Journal of Consulting Psychology, 1(November-December, 1937), 106.

Discussion concerned with the amalgamation of these two societies began in 1942, and the following year an intersociety constitutional convention was held which considered "the kinds of reorganization which might best serve the professional needs of psychology."[44] In 1944, the AAAP voted to go out of existence and become a part of the APA which had voted to adopt a new constitution. The former constitution had stated that the object of the APA was the advancement of psychology as a science. The corresponding statement in the present constitution reads: "The object of the American Psychological Association shall be to advance psychology as a science, and as a profession."[45] According to one author writing in the official journal: "This change is not an idle rewording of the preamble to the constitution, it reflects a real change in the purpose of the association."[46]

At the same time the structure of the APA was reorganized. Instead of an undifferentiated whole, interest groups were recognized by the creation of eighteen relatively autonomous divisions based on subject matter interests or professional differences. In reality the association is

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[44]Dael Wolfle, "The Reorganized American Psychological Association," The American Psychologist, 1(1946), 3.

[45]Ibid., 4. [46]Ibid., 4.

divided into professional and academic segments. A closer analysis of the existing governmental structure and membership characteristics of the APA provided a further illustration of the clinicians' position with regard to having their professional goals realized through association with this parent body. At the present time it is governed by the Council of Representatives which is composed of the executive officers of the association and delegates representing the various divisions. The interesting aspect of this structure is that the number of delegates sent to the Council is determined by the membership size of the division.[47]

In 1962 there were twenty-two divisions of the APA. The seven divisions classified as academic sent twenty-three delegates to the Council of Representatives; the eight divisions considered to be both academic and professional sent thirty-eight representatives; and the seven professional divisions supplied twenty delegates.[48] Examination of these figures suggests an apparent balance of power between the

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[47]"Across the Secretary's Desk," The American Psychologist, 1(January, 1946), 24.

[48]"Officers, Boards, Committees, and Representatives of the American Psychological Association," The American Psychologist, 18(December, 1963), 783-787.

academic and professional segments which has been maintained until the present. However, considering the divisions that are designated as both academic and professional, the applied orientation of the association is more apparent.[49]

A study conducted by Robert C. Tryon for The American Psychologist summarizes the growth of the various divisions between 1948 and 1960 in relation to their degree of professional orientation. According to his classification, the membership size of the academic divisions increased by 54 per cent, while the academic and professional increased 176 per cent, and the professional increased 149 per cent. The ability of these segments to determine the policies of the organization has grown as a consequence of their influence on the Council of Representatives.

A review of recent developments in the field of psychology and within the American Psychological Association in regard to professionalization adequately demonstrates the position of applied psychology in general and clinical psychology specifically. It appears that the decision by the professional specialties to return to the fold of the long established American Psychological Association was a practical one. It was not a rejection of the professional

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[49]For breakdown of the divisions into academic, professional and academic, or strictly professional see p. 48.

PROFESSIONALIZATION IN RELATION TO MEMBERSHIP GROWTH OF APA DIVISIONS, 1960[50]

MOST ACADEMIC

DIVISION	MEMBERSHIP 1948	1960	Increase
1. General	541	596	10%
2. Teaching	186	538	189%
3. Experimental 6. Physiological and Comparative	564	789	63%
5. Evaluation and Measurement	392	638	40%
10. Esthetics	62	118	90%
TOTALS	1,745	2,679	54%

ACADEMIC AND PROFESSIONAL

DIVISION	MEMBERSHIP 1948	1960	Increase
7. Developmental(Child-Adolescent)	350	616	76%
8. Personality and Social	339	1,346	297%
9. SPSSI	393	806	105%
12. Clinical	821	2,376	189%
14. Industrial and Business	186	734	295%
15. Educational	419	555	32%
20. Maturity and Old Age	-	238	New
22. Disability	-	246	New
TOTALS	2,508	6,917	176%

MOST PROFESSIONAL

DIVISION	MEMBERSHIP 1948	1960	Increase
13. Consulting	189	232	23%
16. School	90	712	691%
17. Counseling	467	993	112%
18. Public Service	111	227	105%
19. Military	234	276	18%
21. Engineering	-	273	New
TOTALS	1,091	2,713	149%

[50] Tryon, op. cit., 137. It should be noted that overlapping membership is permitted.

goal but rather an implementation of the decision that this goal could be more easily realized by rejoining the parent body. This was done with the knowledge that it now would function as a professional, as well as scientific, association.

Although the associational relationships of the clinical psychologists have fluctuated over time, there is the constant aim to enter into any formal relationship which will advance the cause of professional psychology and withdraw from those which do not. This has been reflected by the establishment of an independent organization for clinical psychologists, then with the formation of an association for all applied psychologists and finally, the present arrangement which has been maintained for the past twenty years.

This is not to suggest though that it is necessarily a permanent one nor that it has been entirely satisfactory to everyone. In 1945 when the present merger was being suggested, a number of voices were raised in opposition,[51] and alternate proposals concerned with providing greater organisational freedom had been expressed.[52] However, it

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[51]Editorial in Journal of Clinical Psychology, January, 1945, p. 83; and Editorial in Journal of Clinical Psychology, October, 1945, pp. 345-346.

[52]Fredrick C. Thorne, "Editorial Opinion: The Future of APA Division 12," Journal of Clinical Psychology, 17(July, 1961), 326-327.

appears that the majority are generally pleased with the present arrangement although dissatisfaction with the distribution of policy-making positions has been expressed.[53]

Further strain between the academic group and the clinical psychologists is apparent with regard to existing training programs and the organization of curricula in graduate schools. As a number of observers have pointed out, the professionalization process includes the establishment of schools for the training of future practitioners. At first glance it would appear that the clinical psychologists had taken these steps successfully since graduate departments of psychology have been in existence for some time. However, this is not really the case since the type of training offered by these existing departments is more experimental than clinical in orientation.[54]

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[53]It has been noted that in the entire history of the APA all its presidents have been academicians and that the Board of Professional Affairs which is concerned with the development of psychology as a profession has not had an adequate representation of applied psychologists. Fredrick C. Thorne, "Editorial Opinion: The APA Board of Professional Affairs," Journal of Clinical Psychology, 18(April, 1962), 239. Concern has also been expressed over the fact that between 1951 when it was founded and 1957, 87% of the members of the Education and Training Board which approves departments providing programs in clinical psychology were full-time university faculty and only 13% were employed outside of a university department. Carl N. Zinet, "Clinical Training and University Responsibility," Journal of Clinical Psychology, 17(April, 1961), 112.

[54]Alan Gregg et al., The Place of Psychology in an Ideal University. (Cambridge: Harvard University Press,

Consequently, suggestions have been, and are being, made for the reorganization of these departments to meet the demand or for the establishment of new training institutions devoted solely to the training of applied clinical psychologists.[55] Considering the fact that at the present time one-third of all doctorates granted in psychology have been in the clinical area and that a steady increase is predicted such institutions could be supported adequately.[56]

Although this disagreement over the orientation of graduate programs is an obvious source of conflict between the academic and applied divisions of organized psychology, it is also an indication of one of the underlying reasons for the desire of the clinicians to remain in an association such as the American Psychological Association. After World War II the clinical psychologists were confronted with a major decision of organizational strategy with reference to educational facilities. Two obvious courses were

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1947), pp. 31-34; Tryon, op. cit., 138; and Zinet, op. cit., 113.

[55]Lawrence C. Kubie, "Elements in the Medical Curriculum which are Essential in the Training for Psychotherapy," Journal of Clinical Psychology: Monograph Supplemant No. 3, (July, 1948), 51; and Gregg, loc cit.

[56]Forrest L. Vance and Sharon L. MacPhail, "APA Membership Trends and Fields of Specialization of Psychologists Earning Doctoral Degrees Between 1959 and 1962," The American Psychologist, 19(August, 1964), 655.

Consequently, suggestions were made that [illegible] the reorganization of these departments be made [illegible] or for the establishment of new disciplines which are devoted solely to the training of applied clinical psychologists.[55] Considering the fact that at the present time one-third of all doctorates granted in psychology have been in the clinical area and that a steady increase is predicted, such institutions could be supported adequately.[56]

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1947), pp. 31-34; [illegible], S. B., [illegible] 113.

[55]Lawrence S. Kubie, "Pilgrim's Progress [illegible] Curriculum which are Essential in the Training for Psychotherapy," Journal of Clinical Psychopathology and Psychotherapy, [illegible]

[56][illegible] Membership Trends and Fields of Specialization of Psychologists Earning Doctoral Degrees Between 1957 and 1962," The American Psychologist, 19 (August, 1964), 617.

available: the establishment of a new degree in clinical psychology, either in connection with the established departments or through the development of separate training institutions; or the attempt to influence existing departments to provide more clinically oriented programs.

They have apparently chosen the latter course since it presented fewer immediate problems at the time. Accordingly, the rejoining of the APA also placed this group in a position of greater accessibility to the academic administrators of these programs, and, therefore, enhanced the chances of exerting an influence on their content. With the establishment of accreditation boards and procedures for the certification of clinical psychologists, this ability to influence the type of training is further enhanced. However, as previous discussion has indicated this decision may have solved immediate problems, but it has also presented others which have not been fully resolved. Consequently, a reversal of strategy might be indicated with the establishment of a new degree and program administrated by the applied clinical psychologists themselves.[57] In such a case the desire to establish an

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[57]Carl N. Zinet, "Conference on the Professional Preparation of Clinical Psychologists: A Progress Report," The American Psychologist, 20(March, 1965), 232-233.

independent association might also manifest itself again.

Disregarding possible future changes in strategy it would be worthwhile to examine the positive results of past decisions. It is generally recognized that the American Psychological Association as a whole has reflected a great degree of interest in the development of psychology as a profession. This has been indicated by the establishment of committees and boards concerned with applied or professional affairs such as the establishment of the American Board of Examiners in Professional Psychology which has made strides in attempting to raise the standards of practice and training in clinical and allied psychological specialties.[58]

The crucial determinant of the success of the internal organizational strategy, as well as of the ideological appraoch, is the effect it has had on the implementation of external strategy. The effectiveness of these two elements can be measured then by the gains organized clinical psychology has made in approaching professional recognition.

The essential element of clinical psychology's

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[58]Noble H. Kelley, Fillmore H. Sanford, and Kenneth E. Clar, "The Meaning of the ABEPP Diploma, The American Psychologist, 16 (March, 1961), 132-141.

organizational strategy has been the attempt to achieve legal recognition by the state as a group providing service vital to public welfare. Consequently, it is claimed that the service provided is technical and esoteric to the extent of deserving a degree of autonomy in its regulation.[59] This legal recognition has taken form in legislative acts concerned with the certification and licensing of applied clinical psychologists.

The effectiveness of this strategy can be measured by the gains organized psychology has made in implementing such laws. In September of 1963, there were 42 states with some provision for certification or licensure. Most of these provisions (80%) have been adopted since 1955. Although each bill varies in some respects, all provide for a board which examines applicants who wish to call themselves psychologists. This board is composed of members who are either appointed by the state psychological association or recommended to the appointing body. In the great majority of the cases the board of state psychologists administers the law.[60]

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[59]American Psychological Association, The Background of Legislative Proposals for the Certification of Psychologists, A Report Prepared by the Committee on Legislation (Washington: American Psychological Association, 1959), pp. 1-3. (Mimeographed)

[60]American Association of State Psychology Boards,

A certification act recently passed by the New Mexico Senate typifies those approved in other jurisdictions and provides an illustration of the implementation of psychology's ideological strategy. As stated in the legislation its purpose is that:

> . . . in order to safeguard life, health, property and the public welfare of this state, and in order to protect the people of this state against unauthorized, unqualified and improper application of psychology, it is necessary that a proper regulatory authority be established and adequately provided for.[61]

Other sections of this bill include the definition of psychologist and the practice of psychology as "the application of established methods or procedures of understanding, predicting or modifying behavior."[62] The legislation also creates a State Board of Examiners whose members are appointed by the governor from a list of names nominated by the New Mexico Psychological Association. Among other things the Board is authorized to approve, deny,

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Manual on Legal Issues, A Report Prepared by the 1962-63 Committee on Legal Issues, ed. C. R. Myers (Toronto: University of Toronto Press, 1964), pp. 19-23; "Legislation in Various States," The American Psychologist, 8(October, 1953), 572-584.

[61] State of New Mexico, Senate Bill No. 73, section 2, 1963.

[62] Ibid., section 3,d.

revoke, suspend, and renew the certification of psychologist applicants; conduct hearings upon complaints against certified psychologists; and cause the prosecution of any individual violating provisions of the act.

Although licensure or certification cannot be called unique features of professionalism, or of the professionalization process, because of the various other occupations which have gained this form of legal protection, it is apparently an essential element in clinical psychology's strategy. The reason for this development lies in the fact that clinical psychology, if it is to achieve professional status, must take into account and respond to, a group which it perceives as both competitor and model.

Psychiatry is not only a competing group, but it is one whose claim to professionalism is based on the legal recognition and public mandate of medicine. However, and fortunately for organised clinical psychology, the majority of existing legal statutes regulating the practice of medicine are rather vague and present problems of interpretation when applied to the area of mental illness and therapy.[63] This has presented the psychologists with an opportunity to

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[63]Anonymous, "Regulation of Psychological Counseling and Psychotherapy," 475.

revoke, suspend, and perform the certification of psychologist applicants; conduct hearings upon complaints against certified psychologists; and enjoin the performance of any individual violating provisions of the act.

Although licensure or certification cannot be called unique features of professionalism, or of the professionalization process, because of the various other occupations which have gained this form of legal protection, it is apparently an essential element in clinical psychology's strategy. The reason for this development lies in the fact that clinical psychology, if it is to achieve professional status, must take into account and respond to a group which it perceives as both competitor and model.

Psychiatry is not only a competing group, but it is one whose claim to professionalism is based on the legal recognition and public acceptance of medicine. However, unfortunately for organized clinical psychology, the majority of existing legal statutes regulating the practice of medicine are rather vague and present problems of interpretation when applied to the area of mental illness and therapy.[96] This has presented the psychologists with an opportunity to

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[96]Giacomucci, "Regulation of Psychological Counseling and Psychotherapy," 473.

advance their claim of equal competence in certain areas of mental illness and therapy, and to achieve a degree of autonomy without legally encroaching on the professional monopoly of medicine. It has played its part in defining the conditions under which and by whom mental therapy will be administered, and has done so by adhering to the already established method - the legal process.

Another reason for clinical psychology's emphasis on legislative recognition is based on the realization that one of the surest ways to become accepted as a competent alternative to psychiatry is to project the same image which medicine has so successfully developed and maintained. The professional model of medicine, although composed of a number of elements, is symbolized by its existence as an autonomous group representing the power of the state. Since clinical psychology's attempt at professional status is based on the claim that it is as reliable as medicine in the treatment of certain aspects of mental illness, it must also symbolically present a competent alternative to medical psychiatry. This is not to suggest that other aspects of professionalism such as the dedication to a service ideal, the competence of practitioners, rigid standards of training and ethical behavior have been de-emphasized, for they have not been. However, if it were to wait until all these aspects were fully developed, it might

find itself completely and legally denied the right to practice. Its strategy, then, has been to develop an image which may not in reality be similar to medicine's, but which nevertheless symbolizes it.

II. PSYCHIATRY

Although psychiatry is not presented with the same problems as clinical psychology, it nonetheless must overcome certain obstacles in the path of professional status. First, it is insured of legal recognition based on the professional status of medicine; yet it is continuously faced with what it considers to be an encroachment of function on the part of organized clinical psychology. Second, since it has maintained the already established and independent American Psychiatric Association as a vehicle of professionalization, it has little concern over its applied orientation. On the other hand, this presents the problem of insuring the backing of the American Medical Association, an organization which is of crucial importance to the psychiatrists with regard to measures of organizational support. Finally, it has a problem similar to that of the psychologists' and consequently there is similar emphasis in strategy with regard to the training of new practitioners in the specialty.

The strategy of psychiatry in answer to the psychologists' campaign for legal recognition has been

primarily one of reaction. Since the psychiatrists are insured of this legislative protection as licensed M.D.'s they have taken few measures on their own. Sporadic, although unsuccessful, attempts have been made to bring psychotherapy into the legal domain of medical practice. Such legislation attempted to modify existing medical practices acts and define medicine as the diagnosis and treatment of all physical and mental conditions.[64] However, they have had to come to terms with this aspect of clinical psychology's strategy, but not without considerable vacillation.

Immediately after the war when the psychologists adopted this approach, the American Psychiatric Association in conjunction with the American Medical Association went on record as opposing any and all legislation relating to the professionalization of clinical psychology on the grounds that such legislation might infringe upon the practice of psychiatrists. However, between 1953 and 1956 a series of meetings was held between members of the American Psychological Association and the American Psychiatric Association and an agreement was reached that

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[64] Ibid., 477-480; Fillmore H. Sanford, "Across the Secretary's Desk: Relations with Psychiatry," The American Psychologist, 8(April, 1953), 169-170.

the psychiatrists would not oppose certification legislation on the part of the psychologists. Representatives of the AMA did not participate in these meetings and, therefore, continued to maintain their original position. Consequently, in 1957 the American Psychiatric Association reaffirmed its previous position in line with the adamant stand taken by the AMA.[65] However, little formal action has been taken by the APA to prevent the enactment of certification legislation on the part of the psychologists. It should be emphasized though that during this entire period both the AMA and APA opposed all attempts at licensing by the psychologists, as was exemplified by their activities in New York State.[66]

The fluctuation in strategic response by the psychiatrists indicates a basic organizational dilemma similar to the one they faced in relation to a response to

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[65] American Psychological Association, The Background of Legislative Proposals for the Certification of Psychologists, p. 1; W. J. McKeachie and E. L. Hoch, "Psychology in the States," The American Psychologist, 13(February, 1958), 87-88; Fillmore H. Sanford, "Legislation for Psychologists," The American Psychologist, 8(October, 1953), 545; Fillmore H. Sanford, "Summary Report on the 1953 Annual Meeting," The American Psychologist, 8(November, 1953), 639-640; and American Medical Association, "Report of the Committee on Mental Health," Journal of the American Medical Association, 150(December, 1952), 1686-1687.

[66] Anonymous, "The American Medical Association: Power, Purpose, and Politics in Organized Medicine," The Yale Law Journal, 63(May, 1954), 968-969; and The New York Times, April 12, 1951, p. 26, col. 5.

clinical psychology's ideological position.[67] When the American Psychiatric Association chooses to deny the value of certification of clinical psychologists, it is in effect denying the need for regulation in the name of public welfare for a technique which it also employs. In addition, it is opposing legal recognition of a group which it considers competent to treat certain types of mental illness upon referral by a physician or psychiatrist.[68] However, when it chooses to recognize the value of certification it must contend with the more medically oriented AMA and its attitude toward such activities by the psychologists. Its dual problem, then, has been to react to the psychologists, but in so doing to maintain consonance with the AMA.

The problem of insuring the support of organized medicine in the form of the AMA has been one that has troubled this specialty over the years. The associational and organizational strategy pursued by psychiatry has followed a less devious course than that of its rival. Ever since the founding of the American Psychiatric Association in 1844 as the Association of Medical Superintendents of American

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[67] cf. p. 31.

[68] Maurice E. Kirkpatrick, "Training for Psychotherapy with Special Reference to Nonmedical Fields," American Journal of Orthopsychiatry, 19(January, 1949), 2; and Group for the Advancement of Psychiatry, op. cit., 350.

Institutions for the Insane, the psychiatrists as an organized group have remained distinct from the AMA.[69] However, their relationship with general medicine has varied considerably over the years.

The content and structure of this relationship has been determined primarily by the emphasis psychiatry has placed on a medical or psychological interpretation of mental illness as well as the technique employed in its treatment. In its genesis, psychiatry placed particular emphasis on a traditional medical training and the application of approved existing medical techniques. However, with initial developments by applied clinical psychologists and dynamically oriented psychiatrists, its emphasis shifted away from a strictly medical or organic base. This was prompted by the realization that even with the application of the knowledge and techniques available, the psychiatrists were functioning more as warders of the mentally ill rather than as therapists.[70]

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[69]Winfred Overholser, "The Founding and the Fathers of the Association," One Hundred Years of American Psychiatry, ed. J. K. Hall, Gregory Zilboorg, and Henry Alden Bunker (New York: Columbia University Press, 1944), p. 45.

[70]Henry Alden Bunker, "Psychiatry as a Specialty," One Hundred Years of American Psychiatry, ed. J. K. Hall, Gregory Zilboorg, and Henry Alden Bunker (New York: Columbia University Press, 1944), p. 500; and Joseph Warner and C. Scott Moss, "A Century of Medical Treatment at State Hospital No. 1," The American Psychologist, 13(March, 1958), 121.

This shift in approach by the psychiatrists also had a dramatic affect on the American Medical Association's perception of this branch of medicine. Dr. Francis Braceland, a former president of the APA, discussing the comparative orientations of general medicine and psychiatry during this phase of development stated in the Journal of the American Medical Association:

> Medicine was immersed in its newly found scientific phase, and, while building its edifice on the basic physical sciences, it saw no need for attention to disciplines that savored of being "unscientific" . . . Psychiatry was to have no trouble at all in qualifying for a place in the "unscientific" category; in fact, it might have taken first prize, for not only was it 50 years behind general medicine but vague and foreign metaphysical leanings were beginning to appear in its doctrines. This was enough to condemn it on two counts and to further isolate it from the main body of medicine.[71]

This almost complete rejection of psychiatry by general medicine has not been a permanent feature, but neither has it completely disappeared. The partial reacceptance of this specialty into the medical fold appeared with the emergence of psychosomatic medicine. This concept implies a unity of psyche and soma and consequently the importance and unity of both the medical and nonmedical

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[71]Francis J. Braceland, "Psychiatry and the Future of Medical Education," The Journal of the American Medical Association, 157(April, 1955), 1377.

aspects of mental illness and therapy.[72]

The recent trend toward the psychosomatic treatment of mental illness has taken psychiatry a long way on the road to medical acceptance and toward securing a degree of medical support over the administration of psychotherapy. As Harvey L. Smith has pointed out, the psychiatrist may be an embattled physician, but as far as the AMA is concerned he is a physician nonetheless.[73] The relationship of psychiatry as a specialty to general medicine at this point could be characterized as one of both acceptance and rejection. This quality was exemplified by a statement which appeared in a publication after a joint conference held by representatives of the American Psychiatric Association and other M.D.'s. The report stated that the conference members did not underestimate the scientific value of the body of knowledge which psychiatry had constructed in dealing with patients whose symptoms follow established life patterns which are predictable within certain limits. It held, however, that this knowledge is

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[72]Stanley Cobb, "Mind and Body - The Development of Psychosomatic Medicine," Psychiatry in American Life, ed. Charles Rolo (Boston: Little, Brown and Company, 1963), p. 24.

[73]Harvey L. Smith, "Psychiatry in Medicine: Intra- or Inter-Professional Relationships?" The American Journal of Sociology, 63(November, 1957), 288.

presently only auspicious for the development, "in due time," of generally accepted principles to serve as the basis for systematic instruction in the medical specialty of psychiatry.[74]

The American Psychiatric Association, as would be expected, is not satisfied with this marginal status nor with its role as the embattled physician as indicated by the very existence of such joint conferences and statements concerned with the integration of newer more medical techniques into psychiatric practice. It is apparent then that psychiatry is not unaware that its chances of professionalizing are greatly improved if it can convince the public and established fields of medicine that it is a respected and integral part of the medical whole.

The marginality of psychiatry's position in medicine is further demonstrated by the fact that its very place in the medical-training curriculum is a source of conflict and one which must be resolved if the specialty is going to meet the demand for mental health services. Psychiatry as an area of specialized interest and training appeared as a comparatively late development and is presently confronted

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[74]American Psychiatric Association, Psychiatry and Medical Education, Report of the 1951 Conference on Psychiatric Education, ed. John C. Whitehorn, et al. (Washington: American Psychiatric Association, 1952), p. 102.

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[74]American Psychiatric Association, Psychiatry and Medical Education, Report of the 1951 Conference on Psychiatric Education, [illegible] et al. (Washington: American Psychiatric Association, [illegible]), p. 162.

with the problem of securing a place in an already overcrowded schedule.[75] Consequently, the time alloted must be taken away from other interests, but not without a struggle and conflict within the medical schools. The problems confronting psychiatry with relation to this competitive process with clinical psychology is securing adequate personnel and consequently increasing the number of departments, internships and residencies in psychiatry.

Before examining the strategy psychiatry has employed in the attempt to solve this problem and the results, two facts must be kept in mind. First, the rather obvious one that the supply of psychiatrists is linked to the supply of physicians and to the number of graduates who decide to specialize in this area. Second, and less obvious, is that the number of graduates who might choose this unique medical specialty is linked to the interests and training of the type of student most likely to be accepted by medical schools. In summary, psychiatry's problem is twofold: (1) the establishment of training facilities, and (2) the attraction of medical students to the specialty.

As is the case with clinical psychology, ideally

75Harvey L. Smith, "Psychiatry in Medicine: Intra- or Inter-Professional Relations?" 286.

there are two choices open for the development of training facilities: the utilization of existing facilities, in this case medical schools and hospitals, or the creation of new ones. The latter course, however, may be a possible choice, but it is not a feasible one. A survey of the literature on this subject bears out this realization since only one article suggests the possibility of establishing new educational facilities.[76] The major obstacle to such a course is that a psychiatrist must first receive a medical degree from an educational institution approved by the American Medical Association. For a number of reasons, not the least being the precedent it would set, the AMA would not be likely to relinquish this power granted by the state to sub-specialty associations such as the APA.

The only feasible alternatives for the psychiatrists, therefore, is to attempt to influence the type of training offered by existing medical schools and hospital internships and to increase the number of residencies offered in psychiatry. In order to understand this movement completely, a return to a discussion of ideology is necessary since the establishment of departments of psychiatry and changes in the intern programs will not be made without valid

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[76]Robert P. Kemble, "Do We Need Schools for Psychiatry," American Journal of Orthopsychiatry, 15 (October, 1945), 733-736.

justification. The psychiatrists could approach this problem by stating that such departments and the inclusion of psychiatric experience during internship are required to train qualified specialists.[77] However, this claim could easily be countered by other departments which would be affected by such changes by stating that existing conditions are necessary for training in their own area.

Consequently, the psychiatrists have also employed another and more subtle ideological method. This approach states that departments of psychiatry are required not only for the training of specialists but also function valuably by providing all medical students with a knowledge of human behavior requisite to the treatment of all human ailments. Specifically, it is proposed that previous and existing medical education has fostered the approach that man can be understood exclusively through an unfolding of his genetic biological endowment. This approach has failed, however, to take into account human personality and the influence of interpersonal and cultural factors on personality development, and upon physiological functions. Therefore, all

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[77]Charles A. Rymer, "Review of Psychiatric Progress 1945: Psychiatric Education," The American Journal of Psychiatry, 102(January, 1946), 551; and Daniel H. Funkenstein, "The Problem of Increasing the Number of Psychiatrists," The American Journal of Psychiatry, 121(March, 1965), 852-863.

medical students, regardless of their intended area of specialization, require a broader concept of human biology in order to intelligently and effectively apply the knowledge and skills acquired during the training period in order to deal with patients as persons.[78] It is further added that instruction in psychiatry would also help the students to mature emotionally during the years in medical school.[79]

Such an approach is an indication of a desire to minimize the role of psychiatry as a specialty with limited function while emphasing its widespread applicability. It is interesting to compare this ideological approach with the one employed externally as psychiatry confronts clinical psychology and the public.[80] In this instance the ideology is employed that psychiatry's value and importance lies in

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[78]Rymer, op. cit., 548; American Psychiatric Association, Psychiatry and Medical Education, p. 28-29; C. H. Hardin Branch, "Should the Medical Student be Trained to Refer or to Handle His Own Psychiatric Patients," The American Journal of Psychiatry, 121(March, 1965), 851; D. Ewen Cameron, "Presidents' Page: The American Psychiatric Association and Medical Education," The American Journal of Psychiatry, 109(March, 1953), 705; and Allen J. Enelow and Leta McKinney Adler, "Psychiatric Skills and Knowledge for the General Practitioner," The Journal of the American Medical Association, 189(July, 1964), 91-96.

[79]American Psychiatric Association, Psychiatry and Medical Education, p. 23.

[80]cf. pp. 26-36.

medical students regardless of their ultimate area of specialization require a broader knowledge of psychiatry in order to intelligently and effectively apply the knowledge and skills acquired during the training period in order to deal with patients as persons.[78] It is further added that information in psychiatry would also help the students to mature emotionally during the years in medical school.[79]

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[78]Ibid., pp. 27-28; see also the American Psychiatric Association, Psychiatry and Medical Education, p. 27-28; O. H. Hardin Branch, "Should the Medical Student be Trained to Refer or to Handle the Non-Psychiatric Patient?", The American Journal of Psychiatry, 111(March, 1955), 641; D. Ewen Cameron, "The Mental Hygiene: The American Psychiatric Association and Medical Education," The American Journal of Psychiatry, 111(March, 1955), 691; and Allen K. Ebaugh and Leta McKinney Adler, "Psychiatric Skills and Knowledge for the General Practitioner," The Journal of the American Medical Association, 119(July, 1942), 1159.

[79]American Psychiatric Association, Psychiatry and Medical Education, p. 23.

[80]Cf., pp. 25-35.

its existence as a medical specialty providing a unique service. One indication of this situation is that although a body of knowledge necessarily structures the strategy of the professionalization process, it is not required that it be used to prove a definite point, but merely that it be convincing when necessary.

The utilization of this rationale has been quite successful since the majority of medical schools now have departments of psychiatry or at least some instruction in psychiatric techniques. Further the number of residency positions offered in psychiatry have increased substantially over the past two decades.[81] Organized psychiatry is still plagued by a problem, however, since the establishment of greater facilities has not insured an adequate increase in the number of students entering them.[82]

An analysis of manpower trends conducted by Robert Lockman for the American Psychiatric Association indicated that a significant percentage of the residencies in psychiatry have not been filled. The study revealed

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[81]Robert F. Lockman, Development of a Manpower Research Program for the American Psychiatric Association, (Washington: American Psychiatric Association, 1965), p. 15.

[82]George W. Albee and Maguerite Dickey, "Manpower Trends in Three Mental Health Professions," The American Psychologist, 12(1957), 57-59.

that for the 1963 academic year 3,488 residencies or 77 per cent of those available were filled while 1,073 or 23 per cent remained vacant. The trend for the past 12 years is shown in the following table.

RESIDENCIES IN PSYCHIATRY[83]

Academic Year	Offered	Vacant	Filled	% Filled
1952	1,936	566	1,370	71
1953	2,456	672	1,784	73
1954	2,335	703	1,632	70
1955	2,506	706	1,800	72
1956	2,696	746	1,950	72
1957	2,968	802	2,166	73
1958	3,308	797	2,511	76
1959	3,542	772	2,770	78
1960	3,658	649	3,009	82
1961	3,838	652	3,186	83
1962	4,281	853	3,428	80
1963	4,561	1,073	3,488	77

For the American Psychiatric Association this inability to attract students to their specialty is attributed to the general emphasis on physical medicine presented in the medical curriculum and also to the admission policies of these schools which tend to attract and accept applicants

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[83]Lockman, loc. cit.

with this type of scientific orientation in interest and training.[84] This tendency naturally affects the type of people admitted to medical school and allows for the possible exclusion of people who might be potential material for a specialization in psychiatry. It is recognized that the first problem is slowly being overcome with an increase in psychiatric instruction especially in the first few years of medical training. However, the second problem presents greater difficulties for it entails a change in attitude and policy on the part of admission boards. At this point the psychiatrists can do little more than continually stress the importance of psychiatric subject matter to all areas of medicine and, therefore, the importance of attracting students with at least a minimum of interest and training in the social and psychological aspects of medicine.[85]

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[84]American Psychiatric Association, The Psychiatrist: His Training and Development, Report of the 1952 Conference on Psychiatric Education, ed. John C. Whitehorn, et al. (Washington: American Psychiatric Association, 1953), pp. 66-67; John Romero, "Basic Orientation and Education of the Medical Student," The Journal of the American Medical Association, 143(June, 1950), 410; and Funkenstein, op. cit., 855.

[85]Braceland, op. cit., 1380; The negative reaction of the typical medical student to psychiatric subject matter and instruction has been noted in passing by Howard S. Becker, et al., Boys in White: Student Culture in Medical School (Chicago: University of Chicago Press, 1961), pp. 288-289; and Robert K. Merton, George G. Reader and Patricia L. Kendall, The Student Physician (Cambridge: The Commonwealth Fund, 1957), pp. 230-235.

III. EVALUATION AND SUMMARY

Since the advent of this movement toward professional status in 1945, both groups have spent considerable time, energy, and money in the attempt to insure for themselves a dominant position in the application of mental health techniques. Specifically, the clinical psychologists have attempted to establish themselves as equal, if not superior, to the psychiatrists in the treatment of certain types of mental illness; while the psychiatrists have tried to maintain their traditional, though rather tenuous, position with reference to the treatment of all illness.

It is fairly obvious that each group has made certain gains in the quest for the desired goal of professionalism. With respect to solidifying their position within their area of general orientation and insuring the support of their parent associations, both have experienced significant success though many problems, especially in the area of training new specialists, have yet to be resolved.

With respect to solidifying an external position, it has been the clinical psychologists who appear to have taken the most significant steps. Since the campaign for certification began in 1946 nearly every state has granted legal recognition and a certain degree of autonomy to the

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American Psychological Association and, therefore, has extended to the clinical psychologists a more secure legal foundation as they confront organized medicine. On the other hand, the psychiatrists have done little more than react to this strategy while focusing on internal organizational and ideological problems.

With regard to the education of new specialists in both fields, two significant trends have appeared. The first has been the ability of the clinical psychologists to maintain an extensive degree of flexibility with regard to the type of educational programs and facilities which will best serve their interests. The recurrent discussion of developing a new type of program and degree in clinical psychology and the possibility of such a move being taken is an indication of this ability. The psychiatrists, however, exhibit little such flexibility and ability as they confront organized medicine since control over the training rests firmly in the hands of the American Medical Association.

The second significant trend has been the movement of both groups to include certain aspects of the other's traditional training methods and subject matter into its own educational programs.[86] Such a development undoubtedly

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[86]Carl Binger, "The Role of Training in Clinical Psychology in the Education of the Psychiatrist," Journal of Clinical Psychology: Monograph Supplement No. 3, (July 1948), 57-59; and Kubie, loc. cit.

more adequately prepares either practitioner to meet a greater variety of contingencies in the treatment situation. At the same time though it also sharpens the issue over which group is best prepared to treat the mentally ill and further confirms organized medicine's suspicion of encroachment on the part of the clinical psychologists.

The conflict between these groups over the past two decades has resulted in what could presently be described as a stalemate. This situation, however, is not the result of inactivity but has been the result of the ability of each specialty to solidify its own position and also react successfully to the other's strategies and thereby maintain a degree of equilibrium. This condition plus the fact that neither has successfully solved certain common problems barring possible professionalization by either group indicates a continuation of this process.

CHAPTER V

BARRIERS TO PROFESSIONALIZATION

The preceding discussion of ideological and organizational strategy has illustrated how an occupational specialty attempts to achieve the goal of professional status. However, the number of different groups which have sought professionalism as their hallmark and have failed testifies to the fact that the employment of strategy does not in itself insure success. Therefore, it cannot automatically be assumed that these two groups, or even one of them, will eventually exercise the autonomy characteristic of a profession merely because it is desired.

Both clinical psychology and psychiatry are beset by a number of problems which they have yet to solve satisfactorily. Basically, the dilemma revolves around the body of knowledge which has been developed in the study of human behavior and its application to the treatment of mental illness. First, the existence of contradictory claims to professional status based on knowledge and techniques has had a detrimental effect on the public's knowledge of and attitude toward all mental health practitioners. Second, the body of knowledge does not appear to have been developed to the degree of sophistication optimal for the achievement of professional recognition.

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BARRIERS TO PROFESSIONALIZATION

The preceding discussion of ideological and organizational strategy has illustrated how an occupational specialty attempts to achieve the goal of professional status. However, the number of different groups which have sought professionalism as their hallmark and have failed testifies to the fact that the employment of strategy does not in itself insure success. Therefore, it cannot automatically be assumed that these two groups, or even one of them, will eventually acquire the authority characteristic of a profession merely because it so desires.

Both clinical psychology and psychiatry are beset by a number of problems which they have yet to solve satisfactorily. Basically, the dilemma revolves around the body of knowledge which has been developed in the study of human behavior and its application to the treatment of mental illness. First, the emphasis on [illegible] claims to professional status based on knowledge and techniques has had a detrimental effect on the public's knowledge of and attitude toward all mental health practitioners. Second, the body of knowledge does not appear to have been developed to the degree of sophistication optimal for the achievement of professional recognition.

Specifically, serious doubts still exist about the scientific validity of some or all psychological treatment methods. Third, the nature of the body of knowledge itself presents a problem to the resolution of this process through the elimination of a competitor by political means. Simply, does the nature of this knowledge permit either group to eliminate the other?

I. THE COST OF CONFLICT

As Wilensky has pointed out, the success of the professional claim is greatest when "the society evinces strong, widespread consensus regarding the knowledge or doctrine to be applied."[87] It might also be added that a necessary prerequisite to the development of this condition is that the practitioners must evince a consensus regarding the knowledge or doctrine to be applied. Unfortunately for these two occupations this has not been the case since neither the public nor the specialists are in agreement about the value of the skill applied.

With regard to the public, the situation is not too difficult to understand. Any occupation which attempts to professionalize must succeed in developing a high regard

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[87]Harold L. Wilensky, "The Professionalization of Everyone?" The American Journal of Sociology, 70(September, 1964), 138.

and value in the public's mind for the type of service the specialty provides. This task is difficult enough to achieve under optimal conditions. However, at the present time the public is presented with a maze of contradictory claims and demands concerned with the validity of various types of training and theory. This situation obviously compounds immensely the difficulties for either the psychiatrists or clinical psychologists in gaining the public support they so urgently need to professionalize.[88] In short, the public does not have a clear-cut role image of either psychiatry or clinical psychology nor does it hold the high degree of regard for the service which is characteristic of the established professions such as medicine and law.

A number of studies have illustrated the amount of confusion prevalent in the public mind in relation to the mental health complex. Generally, they have revealed that although the public makes a clear distinction between M.D.'s concerned with physical health problems and those concerned with behavioral problems, it does not make connotative distinctions among the subspecialties in the mental health field, but rather attributes a common meaning to all

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[88]American Psychiatric Association, Psychiatry the Press and the Public, Report of a Conference on Special Problems of Communicating Psychiatric Subject Matter to the Public, ed. Wilfred Bloomberg, et al. (Washington: American Psychiatric Association, 1956), xi.

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A number of studies have illuminated the amount of confusion prevalent in the public mind in relation to the mental health complex. Generally, they have revealed that although the public makes a clear distinction between those concerned with physical health problems and those concerned with behavioral problems, it does not make comparable distinctions among the many specialties in the mental health field, but rather attributes a certain sameness to all

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[85] American Psychiatric Association, *Psychiatry, the Press and the Public*: Report of a Conference on Special Problems of Communicating Psychiatric Information to the Public [illegible] (Washington: American Psychiatric Association, [illegible]).

occupational titles with the prefix "psych."[89] Consequently, there is no clear-cut consensus in the mind of the public as to who is best qualified to handle the problem of mental illness.[90]

In summary it appears that two decades of conflict between clinical psychology and psychiatry have not resulted in placing either group in a particularly advantageous position with reference to eventual professionalization. Nor has the emphasis on resolving the problem of competition allowed the mental health specialties to effect an appreciable change in the public's traditionally negative attitude toward mental illness,[91] an attitude which has indirect effects on the value of mental health treatment and therapists.

II. THEORETICAL VALIDITY

The confusion inherent in the field itself about the validity of psychotherapy and the existence of various schools of thought lies at the base of the public's problem.

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[89]Nunnally, op. cit., 64.

[90]Jum C. Nunnally and John M. Kittross, "Public Attitudes Toward Mental Health Professions," The American Psychologist, 13(October, 1958), 589; and Marvin E. Perkins, Elena Padillia and Jack Elinson, "Public Images of Psychiatry: Challenges in Planning Community Mental Health Care," The American Journal of Psychiatry, 121(February, 1965), 748.

[91]Perkins, op. cit., 749-750.

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[90]Jum C. Nunnally and John M. Kittross, "Public Attitudes Toward Mental Health Professions," American Psychologist, 13(October, 1958), 589; and [illegible] Elinson, [illegible] Challenges to Planning Community Mental Health Care," The American Journal of Psychiatry, [illegible] (February, 1965), [illegible].

[91]Perkins, op. cit., 756-760.

It can safely be assumed that if the experts could come to some conclusion about the value of a specific therapy, and if they could agree on some specific points, the problem of communicating with the public would be immensely simplified. However, they have not and the inability to do so can be traced to the existing state of development of this body of knowledge.

Albert Ellis, a contemporary psychotherapist, states the problem clearly: "The fact still remains that many therapists continue to be just as effective with their patients as are just as many supposedly radically different therapists with theirs."[92] Another practitioner tried to solve this problem when he wrote: "Perhaps the best that can be said of the reigning anarchy in psychotherapy is that despite their differences most analysts are honestly in search of a common good: the improvement of the analytic relationship."[93] Another writes: "Clinical observations amply document that many patients benefit from an interpersonal relationship with a professional person when they

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[92]Albert Ellis, "Thoughts on Theory Versus Outcome in Psychotherapy," Psychotherapy, 1(May, 1964), 87. See also: Werner Wolff, Contemporary Psychotherapists Examine Themselves (Springfield: Charles C. Thomas, 1956), passim.

[93]Brock Brower, "Psychotherapy in America - The Contemporary Scene," Psychiatry in American Life, ed. Charles Rolo (Boston: Little, Brown and Company, 1963), p. 36.

are troubled by difficulties in living and seeking help."[94] This prompts the question of whether providing an interpersonal relationship is adequate justification for demanding professional status. This point may have profound implications for the possible outcome of this process.

The confusion not only centers around the validity and value of different schools of thought, but also touches on the validity of any type of purely mental approach. H. J. Eysenck, an M.D. at the London Institute of Psychiatry, conducted a study which showed that there appears to be an inverse relationship between the administration of therapy and recovery from mental illness.[95] His figures show that patients treated by means of psychoanalysis improved to the extent of 44 per cent; patients treated eclectically improved to the extent of 64 per cent; while patients treated by general practitioners improved to the extent of 72 per cent. He concludes: "The figures fail to support the hypothesis that psychotherapy facilitates recovery from neurotic

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[94]Hans H. Stripp, "The Outcome Problem in Psychotherapy: A Rejoinder," Psychotherapy, 1(May, 1964), 101.

[95]H. J. Eysenck, "The Effects of Psychotherapy: An Evaluation," Journal of Consulting Psychotherapy, 16 (October, 1952), 342; and H. J. Eysenck, "The Outcome Problem in Psychotherapy: A Reply," Psychotherapy, 1(May, 1964), 97-100.

disorders."[96] As would be expected, both the method and conclusions of his study were severely criticized from all sides for failing to distinguish among the severity of illness each group of practitioners would be most apt to treat. Nevertheless, the very existence of Eysenck's critical article serves to illustrate the present state of confusion and insecurity in the field itself.

Returning to the question of nonmedical therapy as an interpersonal relationship and the claim to professional status, it has been stated that the ideal base of knowledge for a profession is a combination of intellectual and practical knowing.[97] This means an integration of knowledge partly explicit, i.e. classifications and generalizations, acquired through formal teaching methods, and partly implicit, i.e. an "understanding," achieved through practice and observation.

The theoretical aspects of professional knowledge and the tacit or implied elements combine to make long training necessary, and are employed ideologically to persuade the public of the mystery of the skill. Consequently, this enhances the possibility of the public granting autonomy and monopoly over its application. If an occupation is based on knowledge which

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[96] H. J. Eysenck, "The Effects of Psychotherapy: An Evaluation," 324.

[97] The framework concerned with the optimal base of knowledge for professionalization is based on Wilensky, op. cit., 149-150.

is too vague, it is not likely to achieve the exclusive jurisdiction necessary to professional authority.

It would be worthwhile to analyze the body of knowledge developed by psychiatry and clinical psychology in relation to this implicit-explicit dichotomy. With regard to the degree of tacit knowledge involved in psychotherapy there appears to be little problem. As mentioned, it has been suggested by a number of specialists that the therapeutic instrument employed in this process is the psychotherapist himself as he relates to the patient. One practitioner has stated that in doing therapy, "you check your degree at the door, the only thing that counts is the application of a relationship."[98]

Consequently, at least as far as the public is concerned, there is still much of what can be defined as magical in the practice of psychotherapy. It has also been proposed that this situation is strengthened by the propensity of the therapist to exhibit an aura of omnipotence.[99] It cannot be doubted that psychotherapy may appear to some as a mysterious process compounded out of a nebulous human

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[98]Bower, op. cit., 36. See also: Michael and Enid Balint, Psychotherapeutic Techniques in Medicine (Springfield: Charles C. Thomas, 1962), p. 47.

[99]Arnold Bernstein, On the Nature of Psychotherapy (Garden City: Doubleday and Company, Inc., 1954), p. 1.

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Consequently, at least as far as the public is concerned, there is still much of what can be construed as magical in the practice of psychotherapy. It has already been proposed that this situation is encouraged by the propensity of the therapist to exploit an aura of mysticism.[99] It cannot be doubted that psychotherapy may appear to some as a mysterious process compared with more [illegible]

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[98] Lowery, op. cit., p. [illegible]. [illegible] Balint, Psychotherapeutic Techniques in Medicine (Springfield: Charles C. Thomas, [illegible]), p. [illegible].

[99] Arnold Lazarus, [illegible] Psychotherapy (Garden City: Doubleday and Company, Inc., [illegible]), p. [illegible].

relationship that seems to transcend scientific appraisal. There must naturally appear something magical about treatment in which only psychological contact is made, a procedure during which the therapist refrains from making any physical contact with the patient and further does nothing commonly recognizable as being of material help to the client. Hence there seems to be something strange about the ability to affect health by mere words.[100]

On this score clinical psychology and psychiatry appear to have met the criterion of tacit knowledge with the ability to recognize illness and apply treatment in a rather mysterious manner. It must be remembered, however, that this is only one element of an optimal knowledge base. The other aspect to be considered is the existence of explicit knowledge. At this point the focus shifts to systems of classfiication and tested theoretical hypotheses which are capable of being transferred in a formal manner and applied through observable techniques.

In this area, neither of the mental health specialties presently appear to meet this criterion satisfactorily. However, the emergence of psychosomatic medicine with its emphasis on an integration of traditional medical techniques

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[100] Ibid., 2.

with tacit knowledge may produce profound changes.[101] Nevertheless, modern psychiatry and clinical psychology have not been conspicuously successful in the classification of mental illness although a general breakdown into the categories of psychoses, neurosis and psychosomatic disorders does exist. Consequently, mental illness is usually discussed and treated in terms of symptoms instead of in terms of etiological classifications. An example of the confusion in the system of classification is represented by the term "schizophrenia" which one psychiatrist has suggested functions as an "explain-all" and serves to obscure rather than illuminate a conception of mental illness.[102]

The effect that this emphasis on tacit knowledge and lack of explicit knowledge may have on the ability to professionalize is meaningful especially in a society which places far greater value on science than on mysticism. Taking into consideration that however mysterious the psychotherapeutic process may seem to the public it is still something that appears capable of being accomplished by anyone with special personality characteristics, interest

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[101] The effect this may have on the ability of psychiatry to professionalize and the resolution of this process will be discussed in Chapter VI.

[102] Thomas S. Szasz, "The Problem of Psychiatric Nosology," The American Journal of Psychiatry, 114(November 1957), 412.

and time. It appears then that both specialties are thought of as having little claim to expert scientific knowledge and therefore little claim to public support for professionalization.

III. SELF-CONSCIOUSNESS

The aforementioned problems are ones that have been faced and solved over a period of time by many professionalizing occupations. However, there is another rather unusual problem indirectly related to the body of knowledge that must be resolved if either group is to achieve the goal of professionalism. Succinctly, does the knowledge on which each bases its claim to professionalism permit the elimination of the other in the name of public interest? Specifically, is it possible for an occupational specialty which has devoted itself to the treatment of maladjustment problems such as overaggressiveness permit itself to be aggressive enough to eliminate its competitor in good conscience? Although it would be difficult to make a definitive evaluation as to what effect this might have on the ability of either group to professionalize fully, the implications are clear when it is kept in mind that this process involves power politics to a great extent.

A review of the literature written by practitioners concerned with the competition between these two groups

reveals discussions of "sibling-rivalry," "delusions of grandeur," "inferiority complexes" and "aggression." One psychotherapist commenting on the present state of conflict between clinical psychology and psychiatry claims that there is room for a psychodynamic interpretation of the behavior of the two groups to indicate that both sides need to take stock of their motives in relation to the problems of personal identity and ego strength.[103] Another states that conflict of a nonfactual variety whether in interpersonal or interprofessional relations, is considered by most clinicians to be an expression of some disturbance within the individuals engaged in the conflict. He concludes that this is indeed the case when one observes the behavior exhibited by organized psychology and psychiatry over the administration of therapy.[104] Yet another discussing this situation states: "On all hands one can see behavioral signs of the frustrations . . . Psychologists who are abstracted enough can get a good deal of amusement watching the clinical psychologists try to hold both the service and academic research role."[105]

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[103]William Sloan, "A Basic Problem of Psychology and Psychiatry," Psychology, Psychiatry, and the Public Interest, ed. Maurice H. Krout (Minneapolis: University of Minnesota Press, 1956), p. 541.

[104]Hedda Bolgar, "Psychology and Psychiatry: A Problem of Identity," Psychology, Psychiatry, and the Public Interest, ed. Maurice H. Krout (Minneapolis: University of Minnesota Press, 1956), p. 15.

[105] Starke R. Hathaway, "A Study of Human Behavior:

It must be restated, however, that this situation does not necessarily preclude the possibility of achieving professional status by these two groups. It does present difficulties for either one to professionalize fully to the extent of eliminating the other or exercising complete control over its functioning. A further integration of medical techniques into psychiatric procedures and the concurrent lack of emphasis on a psychological approach may provide this group with a more worthy rationale for its activities. In this instance the increased success of psychosomatic medicine would provide the psychiatrists with a scientific rationale to support its ideological claim to superiority in the treatment of mental illness.

IV. SUMMARY

The previous discussion concerned with barriers to professionalization has illustrated the importance of the body of knowledge for a successful resolution of this process. There are three problems confronting both groups: the cost of conflict, self-consciousness and scientific validity. It would appear that the absence of explicit knowledge presents the greatest difficulties for the achievement of professionalism. The vagueness of this theoretical foundation

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The Clinical Psychologist," The American Psychologist, 13 (June, 1958), 258.

prevents either group from convincing the public that the service it provides has been developed to a level of sophistication characteristic of an established profession which is, therefore, worthy of exercising autonomy over its functioning. For psychiatry it also presents difficulties in being recognized as a legimate medical specialty by other branches of the profession.

Although the existence of barriers necessarily impedes this movement, they do not in themselves indicate a permanent inability to professionalize. Consequently, it is possible through an analysis of existing strategies and developments to recognise a number of possible resolutions to this process.

CHAPTER VI

POSSIBLE RESOLUTIONS

Having taken into consideration the present situation with reference to the strategies employed and the existing barriers to achieving professionalism, the question of possible resolutions remains to be discussed. Since this case study is one of professionalization in process, a number of alternatives rather than a single definite conclusion must be considered. Nonetheless, it is possible to evaluate the feasibility of each alternative actually occurring on the basis of information provided by the previous analysis of the contemporary situation and also by a review of historical events in the field of professionalization.

Accounting for all contingencies, four possible resolutions are presented: (1) neither clinical psychology nor psychiatry will completely professionalize; (2) the two groups will merge to form a mental health profession and enhance the possibility of reaching their goal through the elimination of competition; (3) only one group will professionalize; and (4) the professionalization of both will take place through a division of labor in the treatment of mental illness.

I. NEITHER GROUP WILL PROFESSIONALIZE

The inability of either group to professionalize fully in the sense of exercising complete autonomy and achieving a monopoly over the application of all treatment procedures with regard to mental illness may be indicated by: (1) the present stalemate between clinical psychology and psychiatry; (2) the fact that the majority of the practitioners of both groups are employed as salaried specialists rather than as free "professionals;" and (3) the immature level of development of existing explicit knowledge.

There can be little doubt that the existence of a competitive situation has detrimental effects on the possibility that either group will achieve professionalism. Further, the successful organisational campaign for certification by the clinical psychologists has now provided each group with a solid legal foundation with regard to the treatment of the mentally ill. Each specialty has made ideological claims to competence in certain areas of treatment and each has successfully made the claim valid through legal protection. Consequently, neither group exercises complete autonomy or monopoly over the application of a skill nor does it exercise social control over all practitioners.

This situation has resulted, however, from the

relative inactivity by organized psychiatry in face of clinical psychology's attempt to gain legal recognition. As indicated the psychiatrists' focus of attention has been on securing firm recognition and acceptance within medicine. It would appear that when this solid foundation is achieved and the resulting support of organized medicine is insured the American Psychiatric Association will begin to take steps of its own in the attempt to break this stalemate. Even though the American Psychological Association has gained certification for clinicians, this does not preclude the intrusion of outside control by the AMA through the modification of existing Medical Practices Acts to include jurisdication over the treatment of all illness. If this were to occur, the training and certification of clinical psychologists would indirectly fall under the scrutiny of the AMA and the treatment of patients by psychologists would be supervised by AMA licensed psychiatrists thereby placing clinical psychology in an ancillary role to medicine.

It would appear, then, that any judgement about the continuation of a stalemate would have to be reserved until the American Psychiatric Association commences to employ external organizational means to make good its ideological claims.

The second possible barrier to professionalization

based on the fact that the majority of clinical psychologists and psychiatrists are salaried "bureaucrats" does present special problems, but not unsolvable ones. Other occupational specialties whose practitioners function primarily as salaried personnel in large scale organizations have overcome this handicap. Lortie's study of the anesthesiologists and Woodhouse's study of the city managers illustrates how through successful organization strategy, with special reference to the role-set, both occupations were able to professionalize successfully.[106]

It has also been pointed out that the degree of autonomy exercised by salaried practitioners depneds upon the degree of professionalism of the organization, i.e. a large number of specialist employees and administrators, and whether the services of the professionals involved are scarce. If the answer is affirmative in both instances, as it is with the mental health specialists, the salaried professional may well demand and receive more autonomy than the self-employed practitioner who may be dependent on the

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[106]Dan C. Lortie, "Anesthesia: From Nurse's Work to Medical Specialty," Patients, Physicians and Illness, ed. E. Gartly Jaco (Glencoe: The Free Press, 1958), pp. 405-412; and Charles E. Woodhouse, "The Professional Autonomy of Salaried Specialists: The Case of City Managers" (paper read at the Annual Meetings of the American Sociological Society, Detroit, Michigan, September, 1956).

patronage of a few powerful clients.[107]

The final impediment to professionalization faced by both groups, as stated, is related to the nature and structure of the base of knowledge. The problem of clinical psychology and psychiatry is a lack of scientifically technical theoretical principles. Undoubtedly, this presents immediate problems to both, but the rather recent appearance of these specialties is at the base of this problem. Advances in the ability to comprehend and modify human behavior and personality maladjustment will enhance the possibility of generating public support for professionalization in the future.

In summary, it would seem that although a number of barriers do present themselves, it would not be possible to conclude at this point that any single one is insurmountable. It must be borne in mind that professionalization in some instances has been a process extending over more than a century. The contemporary example of clinical psychology and psychiatry has covered a mere two decades in an intensive manner.

II. A MENTAL HEALTH PROFESSION

The merging of clinical psychology and psychiatry to form a new all-inclusive mental health profession, although difficult to perceive at the present time because of the state of sometimes bitter struggle, may have some plausibility

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107Wilensky, op. cit., 147.

as a possible solution to the conflict. Such a merger of competing occupational groups has historical precedent as exemplified by the development of the English medical profession through the amalgamation of disparate and conflicting sources.

Until 1858 the practice of medicine in Britain was divided among the physicians, the surgeons, and the apothecaries. Each independent subdivision of the profession existed in competition with the others over the treatment of physical illness and trained practitioners through separate training programs. However, with the passage of the Medical Act and the establishment of the General Medical Council in 1858, the three groups were unified to form the present autonomous medical profession.[108]

An examination of present trends and existing relationships between the two groups indicates at least three developments which would facilitate a merger: first, an agreement on a definition of the task which is the treatment of mental illness and the improvement of mental health in general; second, the definite trend by each specialty to expand its educational program to include aspects characteristic of its competitor's educational emphasis; third, inter-professional organizational devices which have been created to coordinate some of the activities between the two associations as well

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[108]Carr-Saunders and Wilson, The Professions, pp. 65-102.

as to minimize the conflict. Although it will not be discussed in this section, the characteristic quality of not being able to embark on any aggressive strategy without critical and somewhat embarrassing self-consciousness would also facilitate a harmonious resolution of this conflict.

The agreement on a definition of the task and the shared value on the improvement of mental health provides a solid foundation for the possibility of a fusion in the future. The greatest obstacle to such a development is presented by the refusal of the American Psychiatric Association to recognize the equal competence of the clinical psychologists. Although the psychologists are critical of the education provided to psychiatrists in preparation for the treatment of patients, they are not so adamant on this point as their competitors are with reference to training in clinical psychology.

Although it could not be stated with absolute certainty, it is very likely that the American Psychiatric Association would yield on this point if it were not for the pressure applied by the AMA. The dilemma facing the psychiatrists is that they recognize with great clarity the dire need for all mental health practitioners and therefore would be willing to seek compromise solutions to resolve this conflict; yet if they were to do so, they would jeopardize their own position within the field of medicine. Paradoxically, the possibility of a merger of the two groups would be enhanced

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by the ability of the psychiatrists to establish a firm base and an accompanying greater degree of intra-professional autonomy as they interact with organized medicine. At the same time, however, as indicated, such a development would also strengthen the ability of the American Psychiatric Association to resolve this conflict on its own terms. Which path is chosen will depend on whether the broad value of mental health can compete with the desire to gain autonomy and a monopoly over this service.

The trend toward an integration of characteristically medical training experiences into clinical psychology programs and the inclusion of a greater emphasis on social science in psychiatric training would also have a dual effect on the eventual outcome of this process. In the first instance it is an indication that each specialty recognizes some value in the other's contribution to the treatment of mental illness. This may result in a more positive rapport and the eventual development of new training programs and degrees combining the knowledge of both groups. On the other hand, the integration of a traditionally nonmedical approach into psychiatric training programs would enable the psychiatrist to function for all practical purposes as a clinical psychologist when desired. However, regardless of the clinical psychologists' knowledge of the physical sciences he could never function as an M.D.

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The trend toward an integration of [illegible] medical training experiences into clinical psychology programs and the inclusion of a greater emphasis on social science in psychiatric training will likewise have a dual effect on the eventual outcome of this process. In the first instance it is an indication that each specialty recognizes some value in the other's contribution to the treatment of mental illness. This in turn will mean more positive rapport and the eventual development of new training programs and courses combining the knowledge of both groups. On the other hand, the integration of a traditionally nonmedical approach into psychiatric training programs would enable the psychiatrist to function for all practical purposes as a clinical psychologist when desired. However, regardless of the clinical psychologist's knowledge of the physical sciences he could never function as an M.D.

psychiatrist. The obvious implications this might have for psychiatry to professionalize at the expense of clinical psychology will be discussed below. At this point attention will be focused on the specific qualities of this trend and the effect it may have on a rapprochement.

For clinical psychology this synthesis has taken shape in a devaluation of academic traditions while emphasizing applied and practical experience in training programs. Specifically, there has been an attempt to play down the clinical psychologists' training and role as a researcher and theorist in order to devote more time to the observation and supervised treatment of patients in a clinical setting. It has also been suggested that there be instilled in clinical psychologists an easiness with the rather unacademic procedure of learning to diagnose and cure without knowing exactly why the diagnosis is correct or the therapy successful. It is further proposed that efforts should be made to determine why they work, but at the same time they should not be rejected simply because they are not understood.[109] In essence it is being suggested that clinical psychologists learn to accomplish through experience what the psychiatrists have been doing for years.

For psychiatry this universalistic approach is

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[109]Miller, op. cit., 44-45.

indicated by the desire to have new practitioners gain a broader knowledge of human behavior by the addition of social science material during the training period and also through the attempt to provide a greater level of theoretical sophistication with respect to mental illness.[110] Specifically, this would mean devoting more time to academic subject matter and developing finer abilities to understand as well as treat mental illness. Consequently psychiatry is exhibiting a desire to place a greater emphasis on what the clinical psychologists have been doing for some time.

This trend clearly indicates that, regardless of their ideological verbalizations, each group recognizes that the existing independent training programs do not adequately prepare either practitioner to treat mental illness. At the present time the American Psychological Association is attempting to remedy this situation by organizing post-doctoral programs in clinical psychology which provide the more desirable experiences and procedures. On the other hand, the American Psychiatric Association has handled this problem through the establishment of desirable residencies. Consequently, if undergraduate schooling is included it takes approximately ten years to produce what either group

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[110]Charles S. Johnson, "The Influence of Social Science on Psychiatry," Mid-Century Psychiatry, ed. Roy R. Grinkler (Springfield: Charles C. Thomas, 1953), pp. 144-156.

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[110] Charles S. [illegible], "The [illegible] of Social Science in Psychiatry," [illegible] Grinker (ed.) [illegible]

would consider an adequately trained therapist.

However, if a new program were established which included the essential elements of both medical and non-medical techniques, the number of years required in training would be reduced appreciably. The present waste of time and money provides the greatest impetus toward a merger of the specialties. Further, such a development would require at the outset the acceptance of each group on an equal basis and would result in the production of practitioners with similar training and knowledge thereby eliminating the conflict over competence.

The final clue to the possible development of a mental health profession is indicated by the existence of inter-organizational mechanisms which serve to minimize conflict and function as channels of communication between the two Associations. Mention has already been made of the joint meetings and reports of committees representing the American Psychological Association and the American Psychiatric Association.[111] These more informal confrontations between influential members of both Associations serve to facilitate interaction which cannot be achieved through formal proclamations and press releases.

It was at one of these meetings that the members of

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[111] cf. pp. 19-20.

the American Psychological Association learned of the activities which led to the American Psychiatric Association's reversal on certification for clinical psychologists.[112] Apparently it was also conveyed informally by the psychiatrists and mentioned just as informally in The American Psychologist that this stand was one of expedience, forced upon them by the AMA.[113] This information greatly lessened the friction between the two by shifting the guilt to the reactionary American Medical Association.

It was also suggested at one of these meetings that the possibility be examined of establishing an inter-associational ethical standards board which would allow psychiatrists to lodge complaints against clinical psychologists and vice versa.[114] Although no such action has been taken as yet, if this board were created it would be only a small step further to the creation of joint licensing boards and consequently joint control over training institutions. The establishment of this dual control over licensing has been used successfully where the activities of one profession tend to infringe upon those of another, as in public accounting and law and engineering and architecture.[115] Although

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[112]American Psychiatric Association and American Psychological Association, loc. cit.

[113]Ibid. " 156.

[114]Ibid.

[115]Anonymous, "Delegation of Governmental Power to Private Groups," 156.

this has not led to an eventual merger, these professions are not nearly as closely related to each other as clinical psychology and psychiatry.

In summary it must be stated that with regard to the present stalemate and conflict between these two groups, such developments may appear to have little significance. However, it must also be iterated that this competitive process has covered only a short distance in time when compared to previous professionalization movements, and further, there has been historical precedent. Consequently, such a development cannot be ruled out completely.

III. THE PROFESSIONALIZATION OF ONE

The feasibility of one group achieving professionalism at the expense of the other could not be predicted on the basis of specific gains made by either over the last two decades. However, the possibility of only clinical psychology or psychiatry professionalizing may be analyzed on the basis of inherent advantages or disadvantages which each possesses vis-a-vis its competitor.

Examining the case of clinical psychology first, it would appear that the greatest advantage it possesses is the ability to effect intra-associational changes through its organizational strategy. Reviewing the developments within the American Psychological Association since the

establishment of the Division of Clinical Psychology in 1946 there can be little doubt that this organization has been functioning as an efficient vehicle for professionalization. Not only have the applied clinical psychologists insured the support of their parent association, but they have also maintained a maximum degree of autonomy as a specialty group.

Concretely, this means the clinical psychologists have the ability to readjust training programs to suit their needs with relative ease when compared to the psychiatrists. Such an advantage enables this group to turn out certified practitioners in greater numbers and in a shorter period of time than their competitors who must operate with great deliberation within their well-structured medical setting. In short, though both groups claim competence in the administration of therapeutic techniques it is the clinical psychologists who are more able to meet the demand for the service which both have helped create.

The corollary advantage the clinical psychologists enjoy through their relationship with the American Psychological Association is that once ideological or organizational strategy is decided upon there is little possibility of confronting intra-professional impediments to its implementation. For example, if the Association's Council of Representatives formally accepts the recommendations of the Committee on relations with Psychiatry, there is

no need to coordinate this policy with any other professional organization.

In general the clinical psychologists have achieved and maintained a degree of flexibility, but at the same time internal autonomy and power far superior to that of their competitors. The most serious disadvantage under which clinical psychology must operate in regard to eventual professionalization is concerned with their limited scope of treatment methods. This disability becomes apparent through a discussion of the advantages the psychiatrists and their Association enjoy as medical specialists.

The problems confronting psychiatrists in general and the American Psychiatric Association specifically as a branch of medicine have been alluded to frequently in the course of this discussion. However, if this relation were one of liabilities only, there would be little difficulty in advancing a confident assumption about the eventual resolution of this process. The most significant advantage they maintain vis-a-vis their competitors is that the psychiatrists enjoy a monopoly over the application of all organic treatment methods while the clinical psychologists do not enjoy the same privilege with regard to psychological or nonmedical techniques. Consequently, although neither group has functional autonomy, psychiatry at least does function with the possible advantages accrued from the

maintenance of a monopoly over certain techniques.

It is fairly obvious that this situation has had little effect on the ability of the psychiatrists to professionalize. However, certain incipient developments indicate that there is a possibility for the psychiatrists to employ this monopoly advantageously in the future. This assumption is based on: (1) the potential ability and the actual trend of psychiatric educational programs to train new practitioners with competence in both psychological and medical techniques; and (2) the importance of technological innovation in the form of more sophisticated and successful psychosomatic treatment procedures. The latter will also have significant indirect advantages in the American Psychiatric Association's attempt to secure the complete support of organized medicine and the public for professionalization.

The existence of the trend has been discussed previously with relation to its possible impact on a merger of clinical psychology and psychiatry. Its importance at this point, however, lies in the ability of psychiatry to maintain this emphasis within the medical curriculum and thereby train practitioners to compete with clinical psychologists with an equal facility in psychological techniques. The implications of this trend are obvious when it is acknowledged that regardless of the psychologists'

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increased comprehension of human biology and medical techniques, they are legally barred from competing with the psychiatrists in this area. It is suggested then that psychiatry has the option of developing into the all-encompassing mental health profession without the necessity of resorting to a merger with clinical psychology.

The relative ineffectiveness of the ability to professionalize through psychiatry's monopoly of medical and physical techniques, such as psychosurgery, insulin and shock therapies, is undoubtedly related to the relative ineffectiveness of the techniques themselves. The successive adoption and rejection of a number of these methods as unfruitful combined with the public's negative attitude toward them has naturally proved to be of little value in securing support for professional status. However, the development of psychosomatic medicine with special reference to the appearance of improved drugs has considerably altered this situation.

Although the effect of this development on the public's attitude toward psychiatry has not yet been measured, it would seem safe to assume it could only be beneficial. Rather than present the image of a specialty which alternates between the application of a vague mystery and the application of drastic physical techniques, it now has the potential to settle into the traditional and more comfortable mold of the physician.

The utilization of psychosomatic techniques by the psychiatrist has also had a profound effect upon its image within medicine as a whole. As it relates to medical acceptance psychiatry has been confronted consistently with the problem of appearing unscientific. The physical techniques it employed were proven to be unsuccessful while successful psychotherapeutic measures could not be proven on the basis of medically sound procedures. However, with the use of drugs the procedure takes on a great deal more respectability in medical circles, since results can be traced to something with which everyone is more familiar and comfortable. Psychiatry's "coming of age" will mean not only acceptance and support as a medical specialty, but also the ability to operate with greater autonomy as it conflicts with psychology over the treatment of mental illness.

Although the emergence of psychosomatic medicine may be interpreted in one way by the public and in another way by medical practitioners, both interpretations can be traced to one appearance of a systematized body of explicit knowledge and techniques. The aura of mystery also so necessary to the projection of professional expertise has not disappeared; however, the situation has altered to one of a more ideal combination of the scientific and mysterious elements as the basis for a professional claim. The possibilities this ideal knowledge base may have on the

culmination of this dual professionalization process are compounded when it is considered that clinical psychology is effectively barred from sharing in present or any future technological advances of this nature.

IV. DUAL PROFESSIONALIZATION

The inclusive examination of all possible resolutions demands the consideration of the feasibility of both clinical psychology and psychiatry professionalizing through a division of labor in the treatment of mental illness. Logic dictates such an analysis since ideally this possible resolution exists. However, existing conditions and trends in strategies preclude the serious consideration of such a conclusion to this process.

Historically and to an extent at the present time, each specialty has trained practitioners with a greater competence in specific treatment techniques through its educational programs. Consequently, it might be assumed that each group could achieve autonomous control over the treatment of specific types of illness. This would require a definition acceptable to both groups which would subdivide mental illness into purely functional or organic types. Further, it would necessitate a recognition by both groups that its competitors maintain a degree of unequalled competence in the treatment of one type.

culmination of this dual professional and personal growth is compounded when it is considered that I have already begun to effectively derive fiscal sharing in present and any future technological advances of this nature.

The most serious impediments to the development of such a condition are: (1) the trend by both groups to include aspects of its competitors' emphasis into its own training programs; and (2) the refusal or inability of the American Psychiatric Association to recognize the value of a purely "psychological" approach in the treatment of mental illness.

It would appear that the present trend toward the inclusion of psychological knowledge and procedures into psychiatric training programs and the greater emphasis of traditionally medical subject matter and treatment methods in clinical psychology programs would preclude such a segmented professionalization. The expansion of the knowledge presently considered valuable to the training of psychiatrists and clinical psychologists has the effect of bringing the groups closer together and, consequently, sharpening the differences between them. A reversal of this trend by each with the emphasis on developing and mastering traditional subject matter and procedures would greatly enhance the possibility of separate professionalization. However, such a reversal in strategy is not indicated at this time.

The second barrier to such a conclusion of this process is presented by the refusal of the American Psychiatric Association to recognize the value of nonmedical treatment procedures. This opinion is clearly and forcefully apparent in its ideological strategy which defines mental

The most serious impediments to the development of such a condition arise: (1) the trend by both groups to include aspects of its competitors' emphasis into its own training programs; and (2) the refusal or inability of the American Psychiatric Association to recognize the value of a primarily "psychological" approach in the treatment of mental illness.

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illness and its treatment in all instances as a medical responsibility. Further, the recognition of the competence of a nonmedically trained group in this regard would continue to sharpen the marginal status of psychiatry as a medical specialty. Specifically, such a move by psychiatry would undermine its effort to achieve recognition as a legitimate medical specialty.

V. SUMMARY

The analysis of all possible resolutions to this dual professionalization movement indicates that no single alternative could be ruled out completely. It would appear that each possibility could be inferred from existing conditions or through the projection of incipient trends into the near future. However, it might be proposed that the least likely possibility would be the inability of either to professionalise. This is not to suggest that real problems do not exist, but rather that obvious solutions present themselves.

It might also be suggested that the final outcome will depend on the strategy psychiatry chooses to follow. Since psychiatry appears to have the ability to develop the optimal body of knowledge for gaining professional status, the choice of attempting to achieve it on their own or in conjunction with clinical psychology through the formation

of a new specialty would be theirs. At some point after resolving intra-professional problems, psychiatry must choose whether functional autonomy would be worth the price it would pay through a drawn-out competition with clinical psychology.

CHAPTER VII

CONCLUSION

The value of the case study approach to any social process lies in the ability to abstract from the specific example studied, concepts which prove to be valuable and applicable in the comprehension of a wider range of related phenomena. Accordingly, a mere descriptive approach to the contemporary process of professionalization as exhibited by clinical psychology and psychiatry would by itself be of little value to the sociological study of occupations and professions.

Consequently, a broad approach has been made in this paper to illustrate a number of generalized qualities which characterize professionalization as a social movement. First, the relationship between professionalism and the arbitrary definition of knowledge was illustrated, in this case mental illness and the appropriate therapy. Second, the relationship between this process and the appearance of new cultural values was considered. Most important in this regard is the effect the ideological strategy of a professionalizing occupation has on generating public support for the remedying of a social problem. As a result, a concurrent greater value is accorded to the occupation which attempts to solve this problem. With respect to clinical psychology and psychiatry,

it was suggested, therefore, that the emergence of the greater value placed on mental health can be understood as a result of the ideological strategies employed by both groups. Third, the significance of ideological and organizational strategy with respect to the ability to professionalize has been illustrated. Finally, it has been proposed that the analysis of the strategies employed by a professionalizing occupation supplies a broad framework for a conceptualization of this process.

The past history of professionalization was primarily one of new occupations attempting to achieve a favored position in the occupational structure through the attainment of functional autonomy. However, more recent history and contemporary examples indicate that the majority of such movements now appear to have their genesis in the segmentation of a specialty from a larger structure. This segmentation may take form in the desire of a particular portion of an academic discipline to apply existing theoretical concepts to the solution of contemporary problems; or it may be expressed in the attempt by a number of practitioners of an existing profession to develop an independent subspecialty which would enjoy a degree of autonomy equal to its parent organization.

In either of these instances the problems faced are: (1) the development and application of an already existing

It was suggested, therefore, that the emergence of the greater value placed on mental health can be understood as a result of the ideological strategies employed by both groups. Third, the significance of ideological and organizational strategy with respect to the ability to [illegible] has been illustrated. Finally, it has been suggested that the analysis of the strategies employed by a professionalizing occupation supplies a useful framework for a more [illegible] of this process.

The past history of professionalization was primarily one of new occupations attempting to achieve a favored position in the occupational structure through the attainment of functional autonomy. However, more recent history and contemporary examples indicate that the majority of such movements now appear to have their genesis in the segmentation of a speciality from a larger occupation. This segmentation may take form in the desire of a particular segment of an academic discipline to apply somewhat theoretical concepts to the solution of contemporary problems; or it may be expressed in the attempt by a number of practitioners of an existing profession to develop an independent speciality which would enjoy a degree of autonomy apart from the parent organization.

In either of these instances the following issues arise: (1) the development and [illegible]

knowledge base in a unique manner; and (2) the modification and reorganization of existing institutional frameworks in a way most beneficial to the achievement of professional autonomy.

Since clinical psychology and psychiatry exemplify both types of this new form, the specific attempt has been made to draw the relationship between the body of knowledge provided by a larger group and the contingencies of successful professionalization by a segmenting subspecialty. The analysis of these two groups has illustrated the crucial role this theoretical foundation plays: (1) in the structuring of organizational and ideological strategy; (2) in presenting barriers to the achievement of professionalism; and (3) in relation to the eventual culmination of this process.

Through the analysis of the professionalization process of clinical psychology and psychiatry it is suggested, therefore, that a majority of contemporary like movements can be understood through an examination of the body of knowledge and techniques available to the occupation and its relationship to strategies employed.

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Through the analysis of the professionalization process of clinical psychology and psychiatry, it is suggested, therefore, that a majority of contemporary professions can be understood through an examination of the body of knowledge and techniques available to the occupation and its relationship to strategies employed.

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