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Fifty years of clinical psychology: Selling our soul to the devil

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Abstract

An account of the post-World War II development of clinical psychology based on the personal experiences and observations of the author is presented. Acceptance of the medical–organic explanation of mental disorder and devotion to one-on-one psychotherapy paid for by health insurance has led clinical psychology to its present state of desperation, grasping at drug-prescription privileges as a way of surviving by further embracing the invalid medical would. Alternatively, only acceptance of the public health strategy of primary prevention, striving for social justice, and thorough grounding in social learning theory will guarantee survival of the field.

Key words: Clinical psychology, Medical model, Mental health history, Prescription privileges, Prevention

Before World War II clinical psychologists were a rare breed. They worked mostly in educational/counseling settings. In 1946 my first graduate-school text in clinical psychology was written by C. M. Louttit (1936), and it was all about work in schools. With psychology's heavy research interest in learning, the alliance with education had been natural and mutually supportive. I have often thought that, with a modest change in direction then, we could have been clinical educational psychologists. It was not to be.

In 1945 the United States found itself victorious against the Axis powers. It also found it had 13 million veterans of World War II, many of whom had service-connected physical and mental damage that legislators believed required free special treatment in Veterans Administration (VA) hospitals and clinics. These hospitals and clinics were few in number, and they were understaffed, underequipped, and undersized—wholly inadequate to the sudden huge task assigned them. The World War I and Spanish–American War veterans already being served were middle-aged and older, their numbers were not large, and any interest in serving them well had been dampened by an American medical establishment that saw the VA system as socialized medicine, not part of the American way. But in 1945 a grateful nation wanted the best care for the brave young men (and small number of women) who required it. Veterans clinics and hospitals had been underfunded and inadequately staffed for many years. Especially neglected were facilities for caring for those World War I veterans who were mental cases. Often they were put into state mental hospitals because no real treatment space was available in the VA. They were comingled on the back wards of the snake pits with other hopeless mental cases. Now this would all change.

Congress approved massive funding to build new VA hospitals and to open new clinics to treat "our boys." All of the new hospitals had psychiatric wards. Some of the new hospitals were completely NP (neuropsychiatric) and some of the new clinics were devoted completely to "mental hygiene."

Many of the new NP VA hospitals were built in the style of general hospitals—with private and semi-private rooms, for example, with outlets in each room for the delivery of oxygen, with central nurses' stations, operating rooms, and so on. Hospital designers did not know much about psychiatric treatment facilities in 1945, but Americans knew these veterans were mentally sick and needed medical treatment by psychiatrists in modern mental hospitals.

The number of psychiatrists in the country at that time was found to be surprisingly low. The reason: to be a psychiatrist one first had to be a medical-school graduate. Any medical doctor (MD) could call himself (they were mostly males) a psychiatrist, or a surgeon, or any other kind of specialist, though most of the small number of psychiatrists had some sort of on-the-job training in a mental hospital or ward. In those days one could join the American

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Psychiatric Association with an MD and just 1 year of mental hospital/clinic experience.

For many years the number of medical-school graduates in the United States had been kept low as a result of strenuous efforts by the American Medical Association (AMA) and the medical establishment in general. Medical students got no financial assistance, thus ensuring that most of them were from wealthy families and/or had a working wife. They often graduated with large debts and required high earnings to pay them off. With the controlled small annual output of MDs, the number who entered the low-paying field of psychiatry was kept very small indeed. Psychiatry was not a popular specialty. Medical school admissions committees often rejected applicants who expressed an interest in psychiatry, because it was not considered real *medicine.* The small field of psychiatry was itself split into opposing camps. One was composed of the neuropsychiatrists who clung to a belief in brain disease as cause; the other major force was the psychoanalytic group, small in number, who were followers of the Freudian system. Psychoanalysis enchanted the intelligentsia and occupied an exalted place in the centers of intellectual fashion like New York and Los Angeles (Albee, 1959).

Freudian-style therapy, often called psychodynamic psychotherapy, competed with the organic therapies like insulin coma, metrazol shock, and, increasingly, electric-caused convulsion therapy. Few of either group of psychiatrists worked in VA hospitals and clinics. Salaries were low in the VA compared to private practice. Many of the VA medical staff were MDs who could not succeed elsewhere.

Who Will Help the Veterans?

Clearly after World War II a great increase in psychiatric personnel was needed but was largely unavailable. Improved VA salaries slowly attracted some barely competent MDs (often General Practitioners) into the system, but they were far from enough. A potential source of new staff was found. By offering internships in VA hospitals and clinics to graduate students in the field of psychology, and by hiring psychologists (often master's level) as staff and intern supervisors, there was suddenly a large new source of mental health personnel. An MD/PhD (James Miller) was found to lead the new VA psychology program.

In 1945 university psychology departments were small. The senior faculty were mostly experimentalists doing research in vision, perception, and especially in learning, with animal labs and mazes common. But now money was available for a large new cohort of clinical psychology graduate students on the GI bill, which paid for tuition, books, and allowed modest support for living expenses. VA internships were available to many. Psychology training in universities exploded. Hundreds of graduate students interested in clinical psychology were enrolled and placed half time in the VA training program. In 1946 I was one of the first in this new group. The American Psychological Association's Board appointed the Shakow Committee, which quickly organized the Boulder Conference out of which came the Boulder Model. We would all be trained as scientist-professionals. (David Shakow was a respected psychologist-researcher at Worcester State Hospital. Unfortunately he accepted the psychiatric model and the psychiatric setting as the best place to train clinical psychologists [Albee, 1969b].) The major early texts used were J. McV. Hunt's (1944) *Personality and the Behavior Disorders* and Carl Rogers' (1942) new book on nondirective *Counseling and Psychotherapy.*

Clinical psychology trainees in the VA were given the job of diagnostic testing, using the new Wechsler–Bellevue Intelligence Test (Wechsler, 1939), the Rorschach (Rorschach, 1921), the Minnesota Multiphasic Personality Inventory (MMPI) (Hathaway & McKinley, 1942), and the Thematic Apperception Test (Murray, 1938). The medical model requires a diagnosis before treatment can begin. Psychiatric diagnosis was unreliable and haphazard, but it was all that was available, and the test results helped define the labels applied. It didn't really matter much because almost all patients received electric shock if any sign of psychosis was present—or even if there wasn't (Albee, 1970b).

At the universities the senior experimental psychology faculty grudgingly hired a sprinkling of clinical psychologists to teach graduate clinical and testing courses. Many of these psychologists had worked in school settings or in state hospitals. Few were competent scholars and thus rarely eligible for tenure. The senior faculty were also paid $50 a day to be VA consultants, and this softened their opposition to clinical training for their departmental clinical program. Fifty dollars does not seem like much today, but in 1946 it was a significant sum.

It is hard to overstate the naiveté of the early clinical psychology graduate students (like me). Almost all were middle-class males, mostly ex-soldiers, airmen, and sailors, respectful of authority, accepting of what we were told, following orders, we embraced the psychiatric model because nothing else was presented to us. (An educational-learning model existed, but Colleges of Education were separate schools, and we clinical trainees had no contact with their courses. Some excellent programs in counseling psychology were developed in Colleges of Education, and many masters' programs in school psychology emerged, but the training funds and status were in clinical psychology. Our professors, equally ignorant, presented no alternative.) In the VA we all accepted this dominant model—the historic medical view that our patients were sick with mental illnesses. It is what the textbooks said too. Dissertations were written on Wechsler–Bellevue subtest patterns in diagnostic groups or on the effects of electric shock on psychotic disease. Psychiatry was in charge and defined the model, treatment agenda, and status. In the VA clinics where I was placed, the orders came down: only MDs could be called "doctor!"

Everyone a Psychotherapist!

The highest status kind of treatment was psychotherapy, often provided by consultant MDs not unwilling to accept money for part-time work. Psychologists and student trainees were eager for experience in psychotherapy. They devoured the writings of Carl Rogers and his disciples. It was the most exciting game in town, but most places restricted psychotherapy to psychiatrists (because, it was explained, others might miss brain tumors and hypothyroidism that only an MD would recognize).

A few highly visible psychologists were able to establish private practices in psychotherapy. People like Rollo May, Albert Ellis, and Erich Fromm wrote exciting books and defied the powerful medical model. A few famous European psychoanalysts without the MD emigrated to America. Freud himself had argued that the MD was not the best preparation for doing psychoanalysis, but the American Psychoanalytic Association required an MD for training. Compromises emerged from the joint committees of the two APAs (psychology and psychiatry). They agreed that psychologists might do therapy under the careful supervision (later genuine collaboration) of psychiatrists or any other physicians.

Despite the strenuous opposition of organized psychiatry and medicine, legal recognition of the private practice of psychology began to succeed state by state. Psychologists working in clinics and hospitals began doing psychotherapy part-time in private practice, often using the office of another professional on evenings and weekends, but they clung to the mental illness model they had learned in their training and their textbooks. Wherever they had worked, psychiatrists had been in charge, often blatantly uneducated and incompetent in psychological knowledge. (The "psychiatrists" who worked in state hospitals were worse—usually trained in Third World medical schools and barely able to speak English, they were in charge.) If you wanted to be a psychologist and earn good money, you swore allegiance to the medical model and closed your eyes to its lack of validity, to the paucity of scientific knowledge on which it was based.

An End to the Snake Pits?

During the 1950s major changes were in the air. It was time to do something about the huge old state hospitals where half a million unfortunates were incarcerated. Many of these places had no trained psychiatrists and often no nurses. Illiterate attendants ruled the back wards. Beatings and rapes of inmates were common. Albert Deutsch (1948) wrote *The Shame of the States.*

Three passionate people—Bob Felix (who was the first Director of the National Institute of Mental Health (NIMH); Mike Gorman, head of a phantom group called the National Committee Against Mental Illness; and Mary Lasker, a major philanthropist-joined to plot and develop the revolution against the state hospital system. Senator Lester Hill, Congressman Mike Fogarty, and medical administrator Boisfeuillet Jones prevailed on President Eisenhower to establish the Joint Commission on Mental Illness and Health (JCMIH) in the mid-1950s. A complicated, well-financed effort, several important reports from Task Forces led to the final report. Marie Jahoda's (1958) group developed a definition of positive mental health that has become a classic statement rooted in social psychology (despite the loud complaints of psychiatrists like Mo Kaufman. (M. Ralph Kaufman, MD, was chair of a reorganized committee on the JCMIH studies after some internal strife. He was Director of Psychiatric Services at Mt. Sinai Hospital in New York. He bemoaned the absence of medical input.) My Task Force Report on Manpower (Albee, 1959) made clear the hopelessness of one-to-one treatment to deal with the epidemic of mental distress, citing the small number of therapists and the vast number of people with serious problems. I chanced on the only answer—primary prevention as practiced in public health. Epidemiology had found the uneven distribution of mental disorders. It was stress, poverty, being female, being an exploited minority-group member, and so on that put certain groups at especially high risk. The final Commission report, *Action for Mental Health* (1961), allowed professionals other than psychiatrists to do brief therapy, but the proposed 2,000 community mental health centers each had to have daycare, beds, and medical control. The medical model remained intact. The centers did have to include consultation and community education (called C and E), often staffed by community psychologists. When funding got tight they were the first to go.

President Kennedy pushed hard for the community mental health centers. For the first time in American history, federal funds were to be used for the care of nonmilitary mental cases. It was not to be. It was "socialized medicine" and strongly opposed by the AMA and by a Congress that was reluctant to pay for staffing the new centers. Over time some 700 centers got off the ground, but conservative federal administrations consistently opposed adequate staff funding. Meanwhile the state hospitals were being emptied. The centers were supposed to catch the people discharged. Haphazard support of the proposed centers was and is insufficient to keep mentally disturbed people off the streets. As funding dried up for the centers, C and E programs were the first to be eliminated. The states were quick to discharge mental patients and to shift costs to federal programs like Medicaid. The number of homeless individuals escalated on the streets.

Meanwhile with NIMH and VA support, the universities continued to churn out clinical psychologists who, after working a few years in tax-supported clinics and hospitals, increasingly found better income from private practice. NIMH also poured money into psychiatric training, but there were too few takers. Those psychologists and psychiatrists who were trained, at tax-payer expense, quickly went into private practice in suburbia (Albee, 1977).

Gradually, health-insurance programs began to pay for psychotherapy as long as those treated had a medical diagnosis. This led to a steady expansion of the conditions labeled "mental illnesses" by official psychiatric nomenclature. By the end of the 1960s psychologists were happy to agree (for money) that the people they were treating had medical illnesses. Leaders in the field of clinical psychology even defended the argument that their patients were sick. Beginning in California, new professional schools of psychology proliferated; they were training psychotherapists but calling them psychologists. The American Psychological Association changed its bylaws for membership (no longer requiring a research dissertation), and the new Psy.D.s (doctor of psychology) all joined. Many of these Psy.D.s did not even have a bachelor's degree in psychology. In 1970 I predicted that there would soon be two national psychological associations: one scientific and one professional, and it came to pass (Albee, 1970a).

Psychology graduate-training programs had been racist and sexist for years. Few Blacks were admitted to graduate school (Albee, 1969a, 1969b). Few women were enrolled (Albee, 1981). It took the women's movement and the civil rights movement to begin to correct these injustices. A psychology faculty composed largely of senior WASP (White Anglo Saxon Protestant) males, with all the narrow-minded biases of this group, was increasingly challenged by new faculty and students to be more socially conscious and activist. Life was not easy for the new arrivals. Tenure, promotion, and degree completion remained largely in the hands of the older WASP males with a narrow definition of the field. For years clinical, graduate students have not been exposed to political issues or to the stresses of people in an exploitative, consumer-oriented racist and sexist society. A majority of clinical psychologists have been choir boys, accepting the status quo—to get along they sang along.

A Time of Hope

For a short time in the 1970s it seemed that things might change. The Commission on Mental Health appointed by President Carter recognized the major influence of poverty and exploitation in the development of emotional distress and urged the establishment of socially focused primary-prevention programs by the NIMH (Task Panel on Prevention, 1978). Rosalynn Carter, honorary chair of the Commission, and Beverly Long, president of the National Mental Health Association, both insisted on the primary-prevention focus in spite of opposition by psychiatrists on the Commission. A new Mental Health Systems Act was passed in the last year of Carter's term. But with the election of Reagan, all of the plans were for naught. The Mental Health Systems Act was repealed, and no further NIMH-supported research on social factors was permitted. A conservative administration joined forces with the National Alliance for the Mentally Ill to insist that all mental disorders are brain diseases rooted in bad genes and bad body chemistry. Miraculously, no costly programs were now needed to correct social injustices or to level the playing field. Social Darwinism ruled again (Albee, 1996).

In exchange for accepting the narrow medical model, financial rewards have been good for clinical psychologists. Sometimes, as the poet Carl Sandburg warned, we have had to eat a mess of cockroaches along the way, as exemplified in the following list of proclamations:

- When the NIMH says "Decade of the Brain" (Brain research will uncover the causes of mental illnesses), we must stand and salute.
- When neuroses are declared nonexistent by the *Diagnostic and Statistical Manual of Mental Disorders* (DSM IV; American Psychiatric Association, 1994), we must stand and salute. (The neuroses suggest childhood trauma as cause. Childhood experiences could be unlearned and prevented, so the idea is dangerous.)
- When the National Alliance for the Mentally Ill and its state and local chapters reject any role for childhood stress, neglect, and abuse in causing mental disorders and argue that mental illnesses are all brain diseases, we must stand and salute.
- When the great popular medical journals (*Time, USA Today, Newsweek,* etc.) declare that new mind-altering drugs will soon cure all our infected brain/mental cases, we not only stand and cheer, but we seek to get prescription-writing privileges for ourselves! The new health-insurance regulations, written to maximize the profits of managed-care companies, are sharply curtailing the income of psychologists in private practice of psychotherapy. The solution? See more of these "sick patients" for fewer sessions and prescribe drugs for their brain pain. The Devil offers a good deal! If we just accept the medical model we will prosper. And the pharmaceutical companies are on our side!

Where Did We Go Wrong?

The history of professions makes it clear that most have begun in the marketplace with apprenticeship training; each has moved onto the university campus as a separate professional school with its own faculty and with apprenticeship training in a captive service-delivery site. Clinical psychology, in contrast, began inside the scholarly arts and sciences graduate school and sent its apprentices out to psychiatric service centers where psychiatric language and theories were taught. I experienced this problem and in 1963 urged the establishment of psychological centers for our own service delivery and training (Albee, 1964), but the federal training money supported the psychiatry model and training in mental hospitals and clinics. To be part of this high-status, well-paid intervention we sold our souls to the Devil—the medical model. Now we have gone so far down this road we may never escape.

What Is the Alternative?

Let me assert the argument that most of the patterns of disturbed behavior and disturbed feelings so common in our society are learned in a social context. Marie Jahoda (1958) was and is right. She told me in the mid-1950s: "All mental disorders are learned patterns of disturbed interpersonal (or intrapersonal) relationships." She continued, "If they are learned, they can be unlearned; but most importantly they can be prevented" (M. Jahoda, personal communication, November 15, 1959). Szasz (1962) is right. Mental illness is a myth. (We must be clear: It is *illness* that is a myth; disturbed behavior is not a myth. This is an important distinction.)

Throughout history the field of public health has long known that no mass disease or disorder has ever been eliminated or significantly reduced by attempts at treating the affected individual. One-to-one treatment doesn't cut it. Psychotherapy is futile (Albee, 1990a, 1990b). Only successful primary prevention reduces incidence, but clinical psychologists do not know this. Their training courses and on-the-job experience give them no reason to doubt their guiding fiction. They can prosper only by treating these sick people one at a time. If we can't do psychotherapy we will give drugs, one by one.

Nor do psychologists have any notion of the epidemiology of emotional disorders. They do not know, for example, that migrant farm workers have much higher rates of alcoholism and schizophrenia than the middle-class clients with whom they work. They do not know that MDs have the highest rate of drug abuse of any group. They are unaware of the pernicious effects of poverty, of involuntary unemployment, of racism, sexism, ageism, and homophobia in producing stress leading to emotional disorders (Albee, 1969, 1981). We have paid attention only to the individual—not to the damaging social environment.

Most important of all, clinical psychologists are not taught that mental disorders are learned. These conditions are not diseases. Most are not disorders of the brain. If they are learned in a social context, then they can be prevented with a revised social order that does not exploit workers, that is not classist, sexist, racist, homophobic, or ageist (Albee, 1996).

Psychology has long had sophistication in the field of learning, but this topic has been neglected in clinical curricula. Mowrer (1950) long ago suggested that emotions are classically conditioned and behavior is instrumentally conditioned. Few clinical psychologists today could explain what this means. But it is a powerful model, once understood.

If clinical psychology is to survive as a field we must:

- Abandon the medical model and make every effort to undermine it, to show it to be invalid. Replace it with a social learning model.
- Teach our students about social justice and injustice and their behavioral consequences. Show how people who are exploited learn emotional distress. Become politically active.
- Join a radical support group in the struggle against the fictions that hold together the exploitative consumer society in which the upper 1% own more than the lowest 90%.

A recent monumental study (Wilkinson, 1996) shows conclusively that those societies that have the smallest differences in income between rich and poor have better health and greater life expectancy. Such societies are more socially cohesive, have lower crime rates, less alcoholism and drug use, and lower rates of emotional distress.

Instead of wasting our time with antiquated invalid models that focus on individual change we must rally together a small group to organize a professional revolution! Up with prevention! Arise, ye prisoners of psychiatry! It was Margaret Mead who said: "Never doubt that a small group of dedicated citizens can change the world; indeed it is the only thing that ever has!" (K. Grady, personal communication, May 1, 1997).

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