THE UNCERTAIN FUTURE OF CLINICAL PSYCHOLOGY [1]

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CLINICAL psychology has entered a paradoxical phase in its development where its problems of identity and relevance threaten it with extinction at the same time that its opportunities seem boundless. The demand for clinical psychologists far exceeds the number available or being trained. While able undergraduates in greater numbers than ever before are knocking on the doors of our graduate schools seeking admission to clinical training programs, these schools are accepting fewer clinical students. Indeed, clinical programs are being dropped or sharply curtailed by many prestigious universities.

Professional psychologists are increasingly critical of existing graduate programs, charging that the curriculum is irrelevant and inappropriate and that deliberate efforts are being made to dry up the supply of future clinicians.

What are some of the forces responsible for this strange state of affairs, where everyone seems eager to expand training in clinical psychology except the field of psychology itself, particularly those fields of scientific psychology that control the graduate programs?

Let me suggest that the basic incompatibilities between the field of clinical psychology and the parent discipline have reached the point where only drastic changes may be effective in preserving the profession.

Our problems in clinical psychology are based in part on the location of our training, because this creates our ideology, our self-image, and our goals, and in part on the fundamental incompatibility of the roles of scientist and professional within one individual. Let me examine these two basic problems in some detail.

Some years ago, Roger Barker suggested that a good way to predict the behavior of a human being is to find out where he is. While I do not wish to take a position that suggests total control of behavior by the immediate environment, I would agree that a person does behave differently in a research lab, at a football game, in a cocktail lounge, and in an APA Council meeting. I would also argue that for 25 years clinical psychologists have behaved in ways responsive to the location of their training, partly in academic departments and partly in psychiatric settings. In both settings, they have been treated as second-class citizens.

Clinical psychology is making the painful discovery that academic departments of psychology in the faculty of arts and sciences are not the best places in which to train professionals and that the psychiatric setting is an unsatisfactory place to learn the ideology of practice. But it is hard to change tradition, even if tradition is only 25 years

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old. Warren Bennis has observed that changing a university is about as easy as reorganizing a cemetery! There will be many serious obstacles to changes in the pattern of training of professional psychology. Let me direct your attention to some of these obstacles.

For one thing, clinical psychology differs in its origins from practically every other major profession. Other professions began as loose organizations of people delivering services needed by society, or segments of society, and the service was delivered in the marketplace. One received one's training by apprenticeship. If you wanted to be a social worker, you went to work in a settlement house or social welfare agency. Aspiring physicians were apprenticed to a practicing doctor. It was possible to "read law" in a lawyer's office. Gradually, following a sociological law which says that aspiring professionals must learn theory and knowledge based on research before learning skills, professional training moved onto the university campus. There it took root with separate professional faculties, separate professional degrees, and, for the most part, separate captive practicum training facilities where students could be apprentices of senior professionals. So, we find that all professional schools teach theory during the early part of their programs, but insure that their fledgling professionals receive extensive apprenticeship training in captive service facilities with successful practitioner role-models who often donate their time to the professional school in exchange for prerogatives such as bed privileges, honorific titles, or free office space and secretarial help.

Clinical psychology has a very different history. I will not tire you with its recitation because it is so familiar. Let me simply remind you that clinical psychology began as a small offshoot of academic, scientific psychology, growing within the confines of the graduate school where professional education was unfamiliar. In addition, I have been pointing out for several years that clinical psychology has owned no captive practicum training facility of its own, and so, like the cuckoo, it has had to place its eggs in other birds' nests. In 1946, graduate departments of psychology accepted the invitation of the Veterans Administration to send clinical students for paid internships in their psychiatric settings. Experience in psychiatric settings quickly became mandatory—with the result that we became members of a Team in a game where we had little influence on the rules and no choice of ballpark. Back home in the graduate department, faculty members teaching clinical courses were often nonscientific, or young, or adjunct, but in most cases low status. The clinical students had the worst of both worlds. Some adapted, some tried to outscience the scientists, and many identified with the aggressor and adopted the values and language of psychiatry. Clinical psychology does not control its own faculty appointments and promotions; instead, recommendations from the department are made to a faculty supercommittee that consists of nonpsychologists including professors from the sciences, arts, and humanities, most of whom are completely uninformed about the special needs and requirements of a *professional* training program. The present PhD programs in clinical psychology must depend for support on budgets controlled by academic vice-presidents, graduate school deans, and department chairmen, most of whom are either unsympathetic toward, or ignorant of, both the financial requirements of professional training, the need for professional staff qualified to teach skills, and the need for our own service-delivery programs for practicum training.

The establishment of separate programs for clinical psychology would be enormously expensive. Federal funding (NIMH) is the most likely source, and it is not a very promising one, not only because of sharply reduced funding in prospect, but also because historically the NIMH has served the psychiatric establishment. In view of its elimination of psychology as a separate branch, together with many indicators in recent years that the powers at NIMH are engaged in decision making that reduces support of psychology training, I see no reason for optimism that very many separate schools of clinical psychology will flourish with NIMH nurturance.

The academic department is the wrong place to teach professional psychology, and the psychiatric setting is the wrong place for apprenticeship training. In psychiatric settings, the clinical psychologist in training learns to speak the language of psychiatry, learns to use and accept the *sickness model,* and often aspires to a career in the private practice of psychotherapy.

In adopting the sickness explanation from psychiatry, the psychologist, perhaps unwittingly, supports those cultural forces of reaction that delay the social changes essential to the prevention of

emotional distress, and that bar intervention by modestly trained therapists. If mentally disturbed individuals are suffering from some unknown and undiscovered illness rather than damaged by a hostile and evil social environment, then the strategy for action calls for discovery of the cause of the disease rather than social action to change the dehumanizing forces of society.

Perhaps the most serious consequence for clinical psychology deriving from its near-total immersion in the psychiatric setting is that clinical psychologists and their students have been exposed to a very narrow range of human problems and, without any real opportunity to think about the matter, have accepted the psychiatric definition, confused as it is, of who is to receive our intervention. As a result, our selected treatment population is largely restricted to the two groups traditionally served in psychiatric settings. The first of these groups, usually found in the general hospital, especially the university hospital, is the white middle-class neurotic who seeks prolonged psychotherapeutic relationships—people whom Schofield has described as having the YAVIS syndrome (young, attractive, verbal, intelligent, and successful). The second group clinical psychology has learned to work with is the seriously disturbed poor who are incarcerated in tax-supported state and Veterans Administration hospitals. These groups are so familiar to us, and we have been brainwashed so long into believing that they represent most of the universe of emotionally disturbed people, that our textbooks, our courses, our case-seminars, our personality theories, and our field work placements for students draw on experience with these groups. If, 25 years ago, enormously increased amounts of federal support for training in psychological intervention had been funneled through the public school system, rather than through psychiatric facilities, the present nature of clinical psychology would have been altogether different. Or, if psychological manpower had been supported and trained through the welfare system, we would be a still different field today.

What I am suggesting to you is that we try now standing back at as great a distance and with as much perspective as we can manage, to see what are the truly most pressing psychological problems that afflict our society, and whether clinical psychology, or some new field of applied psychology like community psychology, might not select these more urgent human emotional problems as our focus after breaking free of psychiatric influence on our choice. Must we work on problems and programs only because financial support for them is available, or can we assume some responsibility for developing public awareness and then public support for intervention with the *real* problems of our society?

Let me suggest to you, as one example, that *racism* is a far more serious, pathological, and deep-seated emotional problem in our society than either the sexual neuroses of latter-day Victorians or the existential neuroses of the affluent. Racists do share some of the pathological symptoms we encounter in the clinic. The racist is delusional. He believes things to be true that are not true because such beliefs serve deep unconscious emotional needs, and his belief is unshakable by reason or logic. How much individual case-study have clinical psychologists done with the individual racist, and where have we studied the epidemiology of racism? Unless our society solves the problems of racism, we are not going to survive as a nation. Does this mental condition not merit our attention? Have we tried to do anything in the way of meaningful intervention with the racists? The mental health field has been enchanted in recent years with the development of store-front intervention centers in the slums where local indigenous workers, knowing the language and culture, have been effective in working with the people of these depressed neighborhoods. But why has clinical psychology not opened its own store-front intervention centers in suburbia, staffed by psychologists who speak the language and understand the white suburban affluent culture, to intervene with the local inhabitants afflicted with racism and other virulent forms of prejudice? Why are we so much less threatened by the neuroses of sex than we are by the neuroses of hate? Perhaps, because psychiatry has had little interest in the pathology of aggression, neither have we.

Similarly, clinical psychology has paid almost no attention to the damaging emotional consequences of discrimination based on sex, and yet sexism, like racism, is almost entirely a psychological process, especially a learning process. Schizophrenia is one of the three major subjects each year in *Psychological Abstracts* reflecting the time, energy, and resources we invest in studying this condition. I am suggesting there are other, more immediate and

pressing social problems that we should turn our attention to, problems not usually defined as "psychiatric" but which are surely psychological.

We have taught our students for years that mental cases include those people who are "dangerous to themselves or others." But we have chosen to intervene with a very restricted range of those who are dangerous to others. Who is more dangerous to his fellow human beings than the sophisticated racist? Racist attitudes and behavior, which can be found in a great many places throughout our social and economic institutions, including our state and federal governments, are far more *dangerous to others* than schizophrenia.

I would suggest as a further example that certain economic philosophies that are prevalent in our society are also exceptionally *dangerous to others*. An economic philosophy that justifies the maximization of profit at the expense of the safety, health, and happiness of the citizen should be as much a concern of the mental health worker, particularly the clinical and community psychologist, as more traditional forms of neurosis. In the last few years, I have been driven to conclude that an affluent white Protestant elite, which controls most of our major corporations and our banking system, and indirectly much of our government at all levels, engages in a mammoth, self-seeking, power- and profit-motivated enterprise which results in inequitable distribution of jobs, resources, and health care, and affects even such fundamentals as life expectancy. The most visible victims are the urban black people, but I would hasten to point out that there are millions of poverty-stricken whites in Appalachia and elsewhere who, together with the American Indians and the Mexican-Americans, are also victimized by the economic system. Women are also victimized and exploited by our system. If professional psychologists were truly concerned with human welfare, we could forget "psychiatric patients" for a century and turn our attention to the psychological causes of racism, sexism, and of the profit motive as sources of danger to the human-centered life.

I am not so quixotic as to believe that clinical psychology can have any immediate dramatic effect on these systems. But if we are not concerned with human contributions to human suffering, who else should be working on these problems?

The assassination of John Kennedy may have been a major mark on the bench of history. It is possible that Kennedy's death marked the demise of liberal optimism for a century. The liberal expectation of the gradual triumph of human sanity and reason has had to yield to the fearful fact that good and humanistic forces may not ultimately overcome. While people in many parts of the world have believed for a long time that injustice and human exploitation are the inexorable laws of life, there has been cause for optimism in our democratic society that man might indeed be his brother's keeper. The death of the young hero sharpened our perceptions so that we are now more receptive to the naked reality of human exploitation and psychopathic manipulation of people by people. Harold Lasswell (1970) said at our Convention last year:

> If the earlier promise was that knowledge would make men free, the contemporary reality seems to be that more men are manipulated without their consent for more purposes by more techniques by fewer men than at any time in history [p. 119].

Surely, the cynical manipulation of the masses by powerful elites is a subject worthy of psychological investigation. Which groups are most "dangerous to others"? Our society locks up overt paranoids. But it pays honor and respect to the industrialist who builds automobiles that are death traps, who sprays our fruit with coal tar poisons, and who shows utter disregard for public good in a simple-minded search for profits and power. Why have clinical psychologists not been concerned with the motivations of the manipulators? When the Congress refuses to include farm workers under minimum wage and health-legislation, it dooms hundreds of thousands of children and adults to lives of hopeless poverty and disease. When giant chemical companies dump deadly poisons into our streams and lakes, psychology should be involved in applying its knowledge to prevention of such destruction.

In brief, the relevance of both our curriculum and of our internship experience must be questioned if we are not to have our roles defined for us by the values and goals of psychiatry and of the prevailing economic philosophy.

But there is another serious problem as well. The truly crippling sources of cognitive dissonance in the professional psychologist, which may ultimately destroy the unity of psychology, are the fundamental differences between the *scientist* and the *professional*. A primary one involves self-

criticism and mutual criticism. *Science* is open, and its knowledge is public. Any discrepancies in knowledge are debated openly. One of the hallmarks of science is its insistence on public disclosure of findings. Graduate students in science are taught that research is not completed until the findings are made public. A freewheeling spirit of incisive mutual and self-criticism, replication, debate, and argument over procedures, findings, and interpretation of data, is ever-present. In sharp contrast, a *profession* must jealously guard its secrets! Historically, one of the hallmarks of a profession has been the *privacy* of its knowledge. If the knowledge of the professional, his techniques, and his skills are available to anyone, and could be performed by anyone, a profession would disintegrate. Secrecy and mystery are essential. Even a special technical language is a universal characteristic of the profession. Why were prescriptions written in Latin? Why does a profession develop its own jargon, its own secret language? Why are professions protected by strict licensing laws that actually proscribe certain of their activities to anyone but the qualified professional?

The first professionals, according to Veblen, were the priests who thousands of years ago guarded the Egyptian temples at night and took the opportunity to observe the transit of the stars in the heavens. They discovered that the flood of the Nile coincided with the juxtaposition of certain stars. Immediately, they had powerful knowledge of great value to their society, and, like professionals ever since, they kept their knowledge *secret,* thus preserving the prestige of their profession, their credibility, and their godlike qualities. While professions exist to *serve* society, they must protect what they know, and they must always pretend to know more than they do in order to retain public confidence. In contrast, science abhors secrecy and does not tolerate faking or pretense.

One of the most serious problems for the *scientist-professional* psychologist (Boulder model) has been the requirement that he play the incompatible game of science, and so subject his techniques, his theories, and his methods to open public, critical, scientific scrutiny. If other professions had to engage in the kind of self-criticism and mutual criticism that clinical psychologists are required to perform, they would be experiencing the same agony as we. Imagine the chaos if public and open debate and criticism were the rule in medical office diagnosis, drug therapies, surgery, etc.

Let me illustrate my point with one example—what could have been clinical psychology's most mysterious and powerful magic—the Rorschach. Here was a procedure that fulfilled most of the criteria establishing the power of an independent profession. The Rorschach belonged to psychology. It had enormous face validity and credibility, and it required long and arduous supervised training before one could be expert in its mysteries and its mystique. Its powers were so great that all sorts of controls had to be placed around the preparation of those who would be using it. Twenty years ago, most of us believed in the art of the Rorschach. The public was fascinated by the magic we owned. Other professions viewed our magic with respect. But along came the hard-nosed scientists, the measurement people, with their questions about reliability and validity, with their split-half techniques, and their demand for public demonstration of the value of our magic under strictly controlled conditions. As a consequence, the Rorschach is quietly disappearing from the professional psychology scene because of our professional sensitivity to the claims of science. Interestingly, the public still believes in the Rorschach. Similarly, the process of psychotherapy—a mysterious alchemy of great power and public interest—has been subjected to controlled studies, to long-term follow-up, to objective evaluation procedures, to the point where it has lost considerable credibility within psychology, although professional ingenuity in inventing new forms of psychotherapy has at least kept pace with the efforts of evaluators to catch up and expose it!

Another related source of conflict: The research methods available to clinical psychology are not as pure and powerful as those in experimental psychology. Inasmuch as the heroes of any profession are the scientists who supply it with its soundest, most valid knowledge, the weaker research methods of the clinician subject him to criticisms that only add to his inferiority feelings. Anthropologists tell us that there are still societies that are unaware of the relationship between sexual intercourse and pregnancy. Many of the relationships important to the clinical psychologist are of this sort, particularly the relationship between childhood experiences and adult behavioral disturbances. The

farther causes and effects are separated in time, or the more occasions where a possible cause is not followed by the possible effect, the more difficult is the relationship to unravel through research. The hundreds of years that elapsed before the discovery of the relationship between syphilis in early adulthood and the development of general paralysis of the insane in middle age was due in part to the long separation in time between cause and effect. Further, many persons with syphilis apparently recovered from their disease and never developed general paralysis. Also, many persons developed paralyses without developing the mental symptoms of paresis. It was so confusing! One widely held explanation of general paralysis linked it to frequent minor trauma to the central nervous system because it was so common in traveling salesmen who had to ride the hard seats of railway cars for thousands of miles each year, while the condition was remarkably absent in clergymen who ordinarily stayed close to home and were not subject to such spine-jarring experiences!

Some of our current clinical hypotheses may sound as ludicrous in another hundred years. But I would argue that the truly significant relationships explaining most psychological disorders will still be discovered to be those between early traumatic conditioning and subsequent adult instrumental acts to avoid the effects of such early painful conditioning. Harry Harlow has given us a clear-cut paradigm from the animal laboratory, and Bruno Bettelheim has provided a rough clinical example with schizophrenic children. Much research in this area does not have the methodological purity to satisfy the experimentalists. While both the scientists and the professionals are concerned with discovering regularities in nature, the scientist, particularly the experimentalist, can choose more powerful methods of demonstrating such regularities. Experiments that impose strict control on the operation of independent variables often lead quickly to the identification of significant relationships. The discovery of regularities in nature is accelerated in psychological labs where pure strains of laboratory animals are available, destruction of cortical tissue can be accomplished, and extreme conditions of stress, sensory deprivation, infantile trauma, and similar drastic manipulations are scientifically acceptable and practical.

On the other hand, the professional, dealing with human lives, is thus restrained by humane and ethical considerations that frequently prohibit such manipulation of experimental variables. The clinician, including the clinical psychologist, often must engage in life-history research rather than experimentation. Any student of research design knows the pitfalls and complexities of such methods, particularly when causes and effects are separated by long periods of time. The discovery of significant relationships is difficult and uncertain. As a result, clinical psychologists are often the recipients of scornful criticism from experimental psychologists because of the flabbiness of their concepts, the looseness of their hypotheses, and the unreliability of their procedures. In a field that accords its highest status to its scientists, the professionals are again second-class and disadvantaged.

There are those scientists who would, if they could, impose a moratorium on professional activities in psychology "until we know more about the causes of deviant behavior." Even in clinical research, the more "rigorous" approach (Spence's Type IV laws seeking relationships between organic substrata and behavior) has higher status than the investigation of Type II laws (relating early experience and behavior), because the experimental or empirical operations are neater, more direct, and more acceptable.

Additional sources of friction and polarization emerging within psychology today involve questions about the appropriateness of lobbying and social action. Some of this activity is meant to improve the economic position of the clinician, as in the case of health insurance coverage. Other efforts are proposed to influence the public, through APA pronouncements, on a range of issues varying from abortion laws and sexism to Vietnam and population control. In general, most scientists in APA take the position that they should engage in political activities as citizens but rarely in the name of psychology. Professionals, on the other hand, have a long history of expressing opinions on issues having direct or indirect consequences for the profession, often in the absence of thoroughgoing knowledge and consensus. Professionals are prepared to testify, to speak out, to pass resolutions, on matters that they regard as destructive to the human condition, or not in their own or the public interest. Professionals do indeed act more godlike, echoing another difference between science and profession. The scientist wants to examine all of the evidence before he takes a stand in a controversy.

He is willing to permit any and all hypotheses a hearing, and he is used to postponing decisions on their validity until more evidence is in. He shies away from committing himself prematurely. The professional, in contrast, is accustomed to making decisions on the basis of incomplete or even scanty evidence—he may be accustomed also to making judgments in life-and-death matters where he has only small odds that he is right. He acts in the best interests, he hopes, of the human condition in the absence of scientific certainty.

Among other professions, for example, social work has passed resolutions on a wide range of social, national, and international problems, and the American Medical Association has relinquished its tax-exempt status in order to participate actively in attempts at influencing legislation—in opposing programs like social security, medicare, health insurance, etc. The National Education Association lobbies actively for teachers' benefits. The sciences, on the other hand, are less inclined to speak out on social issues except where science itself is directly threatened. What is chemistry's position on abortion? What does mathematics have to say about pollution of the environment?

The social sciences are less inhibited in these areas than the natural sciences. The national social science societies most closely involved in the study of human behavior and social phenomena have had experience with disruptive tactics from their students and younger members who are impatient with the conservatism of the "Establishment." The anthropologists, sociologists, political scientists, and psychologists have had their meetings disrupted for two or three years. So have the social workers and psychiatrists. Such confrontation has led to position papers and resolutions on social issues. But there has been less of this sort of activism among the harder sciences.

Psychology has had to agonize for several years over policy questions involving public affairs. Should American psychology speak out on the war, on racism? The ad hoc Committee on Public Affairs, chaired by Leona Tyler (1969), wrestled with these issues and concluded that the Board of Directors should assume full responsibility in the area of public affairs. The Tyler Committee developed some guidelines for decisions about appropriate action. Briefly, it suggested a wide range of possible association action for scientific matters, a somewhat restricted range of possible actions for professional matters, and a limited range of appropriate activities in the general area of social problems.

The Board of Directors further considered this matter at its midsummer meeting in 1969 in Boston and adopted a statement which said, among other things, that APA could take no official stand affirming or denying the validity of any scientific hypothesis.

The cumulative weight of these positions makes APA's response to social issues relatively limited and further polarizes the professionals. Thus, for example, the Association might work energetically to obtain an increase in training and research funds for psychology from federal agencies, or it might take an active role in arguing against the restriction of the use of psychological tests and research. It might prepare a position paper on the comprehensive community health centers program. But it would not take a stand on the conclusions of the Kerner Report, nor on the war in Southeast Asia. While it is likely that a majority of psychologists personally agree with the conclusions of the Kerner Report, and would oppose the war, these are not matters of particular and special relevance to the field of psychology in its scientific functions. Many professionals feel otherwise and mutter about the Establishment in psychology and seek to politicize APA, change its governance structure and its tax status.

The activist also may point to the statement in the Tyler Report (1969) which suggests that mobilization of APA to obtain governmental policy changes "would be made only rarely, in cases where the legislation or policy threatened the continued existence or progress of psychology as a field of knowledge [p. 3]." Is there not evidence, asks the activist, that war, racism, and population growth may indeed threaten the continuing existence of our American society? Serious observers, such as John Gardner, warn that the nation is in real danger of disintegration. If the nation deteriorates, psychology will be among the first whose existence is threatened. Tyrants and totalitarians are not normally supportive of free scientific research, and particularly of free inquiry into human problems. So it might be argued that we live in a time when the very existence of psychology is threatened because the existence of our democratic society is threatened and therefore that it is important that psychology throw its resources into

the efforts to terminate the war, to control population, and to combat racism.

I fear that all these basic incompatibilities between the *science* of psychology and the *profession* of psychology may be so serious as soon to require a separation or divorce. As in most such situations, there will be a period of stress, hostility, charges and countercharges, and disagreement over who stays and who leaves. Looking ahead 10–20 years, I predict that there may be an American Scientific Psychological Association and an American Professional Psychological Association coexisting side by side. Some of us will elect to belong to both organizations. The two organizations might arrive at a friendly property settlement, and both might occupy parts of the present APA building in Washington. The scientists will get their journals and conventions with papers and exhibits, and they will pay modest dues. Their Association will be tax exempt. The professionals may continue to subscribe to scientific journals at reduced rates, but they will surely also pay the higher dues required of a tax-paying society and for the kind of action they are demanding to secure insurance reimbursement for psychotherapy, inclusion under medicare and other health legislation, and the social action activities so much more characteristic of professions than of sciences.

What are the future paths open to clinical psychology?

The *first,* logically, is the perpetuation of the scientist-professional model, with little or no change in the traditional pattern of training as it has been developed since it was established at Boulder and reaffirmed at every subsequent training conference. Under this model, the production of PhDs in clinical psychology took a leap in the early 1950s so that by the end of the 1960s as many clinical psychology PhDs had been produced as PhDs in experimental, comparative, and physiological psychology combined. American universities continue to produce PhDs in clinical psychology numbering about one-third of the total production of doctorates. But it is precisely this model which has been the source of many of the problems that I have pointed to. I do not believe it will survive much longer. There will be attempts to strengthen the scientific aspects of the model—to develop "experimental psychopathology" programs—but these will not be likely to attract the students now seeking training or to satisfy society's need for professional psychologists. There will also be attempts to train professionals in PsyD programs within the graduate school, and these may succeed for a time until the problems of faculty status of professional people and appropriateness of practicum settings catch up.

A *second* road for clinical psychology would be the attempt to establish *separate* professional programs or professional schools of psychology. This alternative has much to recommend it for reasons already examined, and would gain for psychology the benefits of independence from arts and sciences graduate departments and deans, and from unsympathetic experimental traditionalists within our own field. Industrial psychology has already begun to move its graduate programs out of the arts and sciences faculty and into schools of business administration and schools of management. Separate professional schools of clinical psychology are being proposed energetically by the National Council on Graduate Education in Psychology. One such school is already being developed by the California State Psychological Association, and elsewhere (New York, New Jersey) professional schools are on the drawing boards. Professional schools for psychology could train far more people than can be accommodated in PhD programs where languages, dissertations, and other requirements slow down the rate of production. Professional schools can recruit from the very large number of young people motivated toward service careers.

Still another advantage of the separate professional school would be that it would draw on professional psychologists in the community for part-time teaching and supervision. The Chicago Conference on Professional Training very strongly recommended that graduate programs in clinical psychology appoint experienced clinicians to the teaching faculty, and, further, that clinical skills should be rewarded in the same way as research publications and teaching. These recommendations failed to take into account the realities of graduate education—the manner in which points toward promotion and tenure of faculty are accumulated. A professional school, on the other hand, can reward clinical excellence without the approval of graduate school scholars from nonprofessional areas.

There is little question that separate professional schools of psychology will produce primarily *doctoral level* clinicians. Psychology's recent history,

its status needs, and the already established state legislative programs for licensing and certification all would require that the graduates of professional schools be people at the doctoral level. But professional schools could also produce psychological technical specialists at lesser degree levels, something that graduate programs have not been able to do.

The biggest barrier to the establishment of separate professional schools is the enormous expense—including the expense of psychological centers. This may be a barrier so formidable as to be impassable.

A *third* path for clinical psychology is a *new* major alliance with another profession that already owns a professional school with the practicum-training facilities that professional psychology has so desperately lacked for so long. I have been saying for years that as a profession exists to provide services to the surrounding society, such services must be provided in some sort of institution or institutionalized setting owned by the profession. Medicine and surgery have offices and hospitals, and social work has settlement houses and social agencies, and library science has libraries, and dentistry has private offices, and education has schools. In all of these professions, the neophyte, after receiving thorough preparation in the theory, private language, and secret knowledge of his discipline, is sent for apprenticeship to one of these captive institutions, where he learns the skills of the profession and where he is further shaped in his professional role by experienced members of the profession.

Psychology has never possessed such a captive practicum training facility. For a time I thought that psychological centers were the answer for professional psychology. But I failed to recognize that a graduate school in an arts and sciences faculty cannot or will not operate such a center. We have little experience in providing direct clinical services to the public, and we have no deans or administrators who understand the need for such services as part of the training of our young professionals. Nor do our scientific colleagues understand this need.

Ideally, such centers should properly be part of separate and independent professional schools of psychology. But in the interim, they could also belong to someone else. We *could* join forces with another profession and thereby move our training out of the inhospitable environment of the graduate school department.

The programs could be located in medical schools. While I find this idea distasteful for many of the reasons examined above, we must at least consider the possibility of moving clinical psychology programs into departments of medical psychology or psychiatry. Another similar possibility would be for clinical psychology to form an alliance with schools of social work or with schools of education.

We could exchange the teaching of behavioral science courses increasingly demanded by these service professions for permission to use their intervention resources and practicum facilities for the preparation of our own professional students. We could teach personality theory, learning theory, psychopathology, and research methods to medical students, or social work students, or education students, and train our own doctoral students in hospitals, settlement houses, or schools now controlled by one of these professions.

Because I feel that we can never win equality in a struggle with psychiatry and medicine, I favor an alliance with social work or education. We might work out a much happier symbiotic arrangement with one or both of these fields, and we would gain the administrative structure and the practicum facilities for professional training of our own.

A *fourth* alternative would be to take the drastic step of *abandoning* clinical psychology as a separate field. This would be a logical response to the possibly insoluble problems of training clinical psychologists in graduate schools, and the equally difficult problems of establishing either separate professional schools or new alliances with old professions. This last alternative would suggest that graduate departments return to their historic role of preparing scholars and scientists to do the basic research and the teaching of knowledge that will be applied by other professional fields. Learning theory, personality theory, measurement theory, etc., would be *given away* to existing nonpsychology professions. Psychology would become a basic science for the profession of nursing, education, social work, medicine, and perhaps for new professions such as child-care and social welfare. Students seeking service careers in psychology would be steered into other fields. This solution is probably the least palatable to existing clinical psychologists, and perhaps the most attractive to

many psychological scientists. In terms of cold reality, it may turn out to be the most probable solution.

As the hand of psychological science controls the intake valve on aspiring professionals coming into our graduate schools, and as the more prestigious departments cut off, or drastically reduce, the size of the flow into their clinical programs, or as these programs are changed into "experimental psychopathology" programs, and as the new schools of psychology fail to flourish because of the thin economic soil in which they are planted, we may witness the gradual disappearance of clinical psychology.

In any event, clinical psychology is going to disappear from the marketplace for a period of years. We are producing about 500 PhDs a year in clinical psychology in the United States, and with half of this number now taking academic jobs or postdoctoral fellowships, the number of clinical psychologists available for clinical work in traditional settings is so small as to be inconsequential.

Still another factor adds to the probability that clinical psychologists will disappear from view. This is the *impending shortage* of *academicians* in psychology that will lure clinical PhDs into teaching.

The National Education Association reports that college professors are lost, through retirement, death, or for other reasons, at a rate of approximately 5% a year. This means that the productive life of the college teacher, all factors considered, averages about 20 years. (The average age of receipt of the PhD in psychology is 30.)

But psychology has had a far smaller rate of loss. Among academic disciplines, psychology has been a relatively *young* field. Most present academic psychologists entered the field of college teaching after World War II, and so college teachers of psychology are younger than college teachers of English, history, or physical education. In addition, psychology is increasingly popular as an undergraduate subject, and so we have added young faculty to teach it. In undergraduate enrollment, we have moved from an obscure twentieth place before World War II to position Number 1 today. Psychology professors have been young and numerous. But now we are entering a new decade, *20 years* past the time when psychology took its great leap forward. I predict that our replacement need for college professors will take a substantial leap very soon. While much has been written in the popular press about the glut of scientists in the academic world, this situation clearly does not apply to psychology. Very soon we will witness a large-scale scramble for new psychology teachers as replacements for retirees. It will come first from the four-year liberal arts colleges where, as a general rule, college faculty members are older than in the universities. The frequent suggestion that graduate departments cut back on the production of psychologists, is based on a misreading of what is going to happen in academic psychology.

In summary, clinical psychology, as we have known it during the past 25 years, is unlikely to continue unchanged. I have tried to suggest some of the forces I see operating in the field that will influence its future. My feeling is that we will see a growing cleavage between scientific and professional psychology, that there will be an expansion of clinical training somewhere outside the graduate department, probably in separate professional schools. Finding the roles of scientist and of professional incompatible when existing *within the same individual* does not mean that scientists and professionals do not need each other. The two groups must exist in a mutually rewarding and symbiotic relationship. I feel that both science and profession will benefit from the impending division, and psychology can truly move forward in both areas as a means of promoting human welfare.

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