CONCEPTUAL MODELS AND MANPOWER REQUIREMENTS IN PSYCHOLOGY

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IT is increasingly clear that the current and the prospective professional manpower shortages in the mental health field derive primarily from a set of interacting considerations that go somewhat as follows:

Disturbed and disturbing human behavior currently is "explained" by a conceptual model which attributes causation to "disease" or to some form of "illness." The content of the explanatory model accounting for these sorts of human deviation dictates the specific kind of institutional structure which society must support for the delivery of care or intervention. And the nature of the institution in turn dictates the kind of manpower required for its staffing. So we are confronted with a desperate shortage of medical and paramedical professionals required to staff hospitals, clinics, and centers. This shortage is going to worsen in the years ahead as the institutional demands proliferate while the manpower supply does not.

Because of the primacy of the disease explanation for disturbed behavior, the largest share of available funds for training and for research is funneled into biomedical programs. These training programs are producing professionals who, after being trained at public expense, do not work primarily with these serious, chronically disturbed people who are the responsibility of tax-supported institutions (Arnhoff & Shriver, 1967). And, further, the biomedically oriented research programs demanded by the disease model support complex laboratory research studies that have little relevance to the real etiological problems of disturbed people.

There is a current, popular platitude which says that the social and behavioral sciences seriously lag the physical and biological sciences in knowledge. If only, it is opined, we could make faster progress in behavioral science, if only we could learn as much about the human being as we know already about germs and atoms, then more effective programs could be developed to deal with man's problems with himself and with his fellows.

This reading of the knowledge situation is far from accurate. We *do* know a great deal in the behavioral sciences, but many of the things we know are threatening to the mental health Establishment and therefore to the status quo. For example, we know very well that *the nature of the social world of the infant and child in the family* are of primary importance as determinants of subsequent rates of disturbed behavior. In our Western culture the stable family is the best bulwark against later behavioral and emotional disturbance. Efforts at prevention of mental disorder should be directed to those social institutions that affect family stability directly or indirectly, positively or negatively. For hopelessly disrupted families we should seek new ways of providing the best possible alternatives for the children affected—whether in foster homes or specially designed institutions like kibbutzim.

When eventually alternative explanatory models for disturbed behavior are widely tolerated, and institutions based on them supported with public funds are available, there will still be real mental illness to keep busy the organically oriented psychiatrist. All of the emotional problems associated with serious central nervous system malfunctioning, seizure states, toxic and endocrinologically induced psychoses, and the problems of organically induced behavioral disturbances in general will be left. But of course these are not the conditions that interest contemporary psychiatry, perhaps in part because there is so little token reinforcement with these kinds of cases! Psychotherapy is the primary professional activity in psychiatry, and mild neurotics are the preferred cases.

The mental health establishment has made so many promises to so many groups in our society that it is beyond the wildest manpower dream that it can begin to supply these services (Albee, 1967). Let me just mention some of these new demands without elaborating them.

The labor unions, particularly the United Auto

Workers, have negotiated contracts for outpatient psychiatric care for their members and families—more than two and a half million UAW people suddenly have become eligible for outpatient mental health care. Other unions actively are establishing their own mental health clinics. Once one union does these things other unions must begin to do them too, and all of these new plans require scarce professional manpower.

Perhaps the single most important recent legislative act in this whole field, so far as manpower demand is concerned, was Medicare. Without going through all of the different components of Medicare, it can be said for sure that an enormous new group of users of mental health services suddenly is eligible for prepaid or insured care. One of the most important parts of Medicare is Title 19, under which anyone defined as "medically indigent," along with their children, is eligible for outpatient psychiatric care and other mental health services. There will be very large new demands for professional mental health care under this law.

Nor need we dwell long on the 2,000 new comprehensive mental health centers that the National Institute of Mental Health promises will be built by 1980 with Federal, state, and local funds. The demand for professional medical and paramedical care in these centers is beyond all hope of realization. How can the 2,000 centers be staffed when two-thirds of our existing 2,000 psychiatric clinics are without a single full-time psychiatrist, and when little psychiatric care is available in at least one-third of our state hospitals (National Committee against Mental Illness, 1966)?

There is no point in discussing the Appalachian program, although it contains more extensive blueprints for programs in mental health than the whole Comprehensive Community Mental Health Centers Act!

Nor need there be further elaboration on current manpower shortages in all the other professions represented in the 2,000 existing "psychiatric" clinics, the VA hospitals, the state hospitals, in higher education, etc. The point I hope to leave with you in this recitation of the growing demand for mental health services is this: All of the plans for increasing professional services for the aged, for the union members and their families, for the medically indigent, for the inner-city poor, and for all the others lining up for care—all of these programs are going to fail because we do not have enough of the *kind* of manpower demanded by the disease model of mental disorder.

It is so simple. The explanatory model dictates the kind of professional manpower needed to staff the institutions. This means a current and future need for nonexistent medical and paramedical professionals. Since 1958, when the Bane report was made to the Secretary of Health, Education, and Welfare (Bane, 1959), it has been the consensus of all manpower experts that we should be producing at least 11,000 physicians a year in this country, if we are only to stay even in the ratio of physicians to population! But we are not training this number. Currently we are training only 7,500 annually—so, year after year, we fall at least 3,500 new MDs farther behind the number that would be required just to keep our ratio of physicians to population constant. The only possible conclusion is that physicians, and, as a consequence, psychiatrists, are going to be in even shorter supply, while all of these service demands I sketched a moment ago are mushrooming everywhere.

Elsewhere I have argued that the future available supply of clinical psychologists and social workers is at least as inadequate as the prospective supply in psychiatry (Albee, 1967). The demands for academicians in psychology, for example, can absorb most of the PhDs we produce over the next decade or two. Because psychology is a relatively young profession there has not been a large replacement demand for faculty members in this field. In other academic fields this replacement figure approaches 6% a year. As psychology professors continue to age we will need to hire replacements in addition to those needed for the expanding student enrollments.

Any manpower planning for mental health care as now conceived must confront explicitly these prospective chronic shortages of professionals. If we continue to use the illness model of mental disorder, we cannot produce a fraction of the medical and paramedical people the model demands. This would not be a sufficient reason for abandoning the illness model, if it were supported firmly by research evidence. But the evidence supporting it is thin indeed. What I am suggesting is that we are in a manpower cul-de-sac because of the conceptual model we use. The development of alternative models could lead to new manpower solutions because they would allow for new institutional solu-

tions requiring manpower more easily recruited and trained.

Eventually the demands of society will prevail. The times are ripe for new models, for new ideas. We cannot push along this social change unless we develop a new set of concepts, a new conceptual armamentarium, a new language, a new delivery system for service.

This reconceptualization must follow rejection by psychology of the illness model. But it is not simply a matter of blowing a trumpet and seeing the walls collapse! The illness model is supported by powerful forces. There are many reasons for its persistence in the field of functional behavior disorder (Albee, 1967).

The model was developed, and it has persisted, because it was more convincing than the sin, taint, or demonic explanations. Also, the early success in finding the spirochete to be the cause of paresis led to hopes that other mental "illnesses" also had similar causes. Further, it seemed more and more as though genetic factors were important. The illness explanation also supported the practice of putting victims out of sight in plague houses until "a cure" was found. Money could be spent on chemical and biological research, without upsetting the value hierarchy in the society. Finally, both family and society could avoid personal responsibility for mental disorder. They could blame *Fate*.

Perhaps, however, the most compelling reason of all for the persistence of this model has been the absence of any alternative model. A scientific model will persist until a more valid and more convincing model appears.

Over the past 20 years there have begun to emerge out of psychotherapy, experimental work in the learning laboratory, cultural anthropology, and social work, to name just a few sources, elements of an explanatory model for disturbed behavior which might be called the *social learning theory*. This theory argues that most disturbed behavior consists of learned operant anxiety-avoiding responses. The origins of the anxiety to be avoided are to be found in traumatic social interaction of infants and children with the parents or parent surrogates. Evidence to support this explanatory model is accumulating in the research literature.

I suggest that as psychologists we have played the illness game for 20 years and this is long enough. The rules of the illness game are such that there will never be enough professional people available to provide care except to selected members of the middle and upper classes. As long as the illness model occupies the center of the stage, all of the planning, all of the action is going to deal with psychiatric treatment, mental hospital beds, and the Team. Psychology must create its own institutional structure for developing methods for the delivery of service, because only in its own structure can it begin to elaborate this new conceptual model—the dimensions of which I have sketched so briefly—together with the language and the intervention methods that eventually will permit people with a bachelor's degree (or even less education) to be the line workers in the field of behavioral disorders.

Let me emphasize that I do *not* see psychology as the care-delivery field. We can never have the manpower to meet the demands. Rather, we must create the theory and show how it is applicable, to enable care to be given by bachelor's level people in habilitation centers that they themselves administer. Psychology can only be the developer of the conceptual models and of the research underpinning. The parallel with the field of education is evident. Intervention in the educational system is by bachelor's level teachers who are supported by more highly trained research workers from several fields. Only when institutions are built in which BA people can work with disturbed or retarded children and adults (perhaps Project Re-ed is the best example of what I have in mind) will we begin to meet the demand.

Frankly, I find it astonishing that all of us as parents, and as citizens, are willing to send our children to the daily ministrations of school teachers trained essentially at the bachelor's level, and yet we insist that professionals dealing with our emotionally disturbed and mentally retarded children and adults must have far more training than teachers for their face-to-face intervention.

Let us start developing an institutional structure where the rules and language are based on research findings in behavior modification. Let us develop centers where technicians, nonprofessionals, rehabilitation workers of all kinds can be used to maximize human potential. Until we have a conceptual assessment system that uses indications of strength we will still be playing the illness game. The new model which I think we must develop will stress the maximization of human effectiveness. I have argued that this model will not be built until

psychology develops it in its own service delivery setting from which we can also go out into those community agencies where the real problems are.

Once society accepts the position that most, if not all, functionally disturbed behavior represents learned patterns of anxiety avoidance, the institutions developed to deal with these conditions may well be *educational* in nature.

Albert Bandura (1967) has said it well:

> The day may not be far off when psychological disorders will be treated not in hospitals or mental hygiene clinics but in comprehensive "learning centers," when clients will be considered not patients suffering from hidden psychic pathologies but responsible people who participate actively in developing their own potentialities [p. 86].

Unless psychology assumes leadership in developing alternatives to the illness model, the mental health manpower picture is going to continue to get worse. We cannot train enough medical and paramedical professionals to meet the manpower needs of hospitals and clinics, but, more important, we cannot use knowledge already available to deal with the pressing problems of our urbanized, automated antihuman existence.

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