CHAPTER 2

Psychology as a Profession

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WHAT DEFINES A PROFESSION?

Originally, there were three professions: law, medicine, and the clergy. These fields of endeavor were distinct from “trades” in that they required highly specialized education, created their own languages—generally not understood by the populace at large—and developed their own standards of practice, ethics, and so forth. In contrast to science, which traditionally published its newfound knowledge, the professions kept their knowledge to themselves. For example, the priests of the Mayans knew by their sophisticated astronomy when the eclipses of the sun and moon would be, and used their predictive powers to ensure that citizens paid the appropriate taxes.

In time, the word profession was no longer used exclusively for the three original fields, but rather for any career requiring higher education; today one can hear the terms “profession” and “job” used almost interchangeably. Colloquial usage of the term notwithstanding, the hallmarks of a profession are still commonly understood to be specialized education, exchange of information (e.g., through journals, books, or seminars), accepted standards of practice, and governmental certification and/or licensing. How psychologists achieved professional status is discussed in

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PIONEERING APPLICATIONS OF的心理学科学


By 1892, the year in which he founded the American Psychological Association (APA), Clark University president G. Stanley Hall (1844–1924) was the recognized leader of the child study movement in America, a national movement that was directed at educational reform. Hall and his colleagues at Clark organized a research effort using schoolteachers, parents, and college educators (including psychologists) to collect data on children, largely through the use of questionnaires, that would lead to a total understanding of the child. With this understanding, teachers could be better trained, school curricula could be better designed, and education could be better suited to individual student needs. Clark University served as a clearinghouse for these studies, accumulating data from more than 190 different questionnaires. Various universities with child study interests (such as Clark, Stanford University, and the Universities of Illinois and Nebraska) held summer programs for schoolteachers, administrators, and educators in normal colleges (i.e., colleges in which teachers were trained) to dispense the new knowledge of the child and to describe the implications of this knowledge for teacher training and school reform (Davidson & Benjamin, 1987).

Although questionnaires were the principal research tools of child study, various mental tests were also employed. The mental tests were an outgrowth of the anthropometric tests developed by Francis Galton (1822–1911) in England in the 1880s and imported to America by James McKeen Cattell (1860–1944). Cattell actually coined the term mental test in an 1890 article in which he described a proposed program of research based on sensory, motor, and cognitive measures (Cattell, 1890; Sokal, 1982b). A few years later he was confident enough in the validity of the measures to suggest that they had value in school settings as “a useful indication of the progress, condition, and aptitudes of the pupil” and further, that these “tests might serve as a means of training and education” (Cattell, 1893, p. 257). By 1895, several American psychology laboratories had adopted a similar mode of testing and were using the tests as diagnostic instruments, principally of intellectual functioning. This was the start of a measurement of individual differences that would define American psychology, particularly applied psychology, throughout the 20th century.

Another of the pioneers in applied psychology was a University of Pennsylvania professor, Lightner Witmer (1867–1956), who in 1896 opened the first psychology clinic in America, and perhaps in the world. In March of that year, a local schoolteacher brought a 14-year-old boy to see Witmer. The boy had difficulties with spelling, and the teacher reasoned that if psychology was the science of mind, then it ought to be able to solve such problems. Witmer dealt with the boy’s problem successfully. By the summer, Witmer was seeing similar cases at the university, which led to the opening of his clinic (Baker, 1988). So enthused was he with this applied success that he gave an address at the annual meeting of the APA that December in which he spoke about using psychology to solve learning difficulties in schoolchildren. He urged his colleagues to use their science to “throw light upon the problems that confront humanity” (Witmer, 1897, p. 116).

The clinic grew slowly at first, with Witmer handling much of the caseload himself—mostly schoolchildren presenting with learning and/or behavioral problems. In 1907, he began editing and publishing a new journal, The Psychological Clinic, in which he described the cases and the diagnostic and treatment methods used. In the first issue of that journal, Witmer outlined a program of graduate training in a field he designated as “clinical psychology” (Witmer, 1907). Based on the work in his
clinic and his promotional efforts on behalf of applying psychology to the remediation of learning and behavioral problems, Witmer has generally been acknowledged as the founder of clinical psychology and school psychology in America (McReynolds, 1997).

In addition to schools and clinics, the new psychology also quickly found its way into the world of business. In the fall of 1895, Harlow Gale (1862–1945), a psychology instructor at the University of Minnesota, began his research on the psychology of advertising. He sent a brief questionnaire to approximately 200 businesses in the Minneapolis–St. Paul area asking them about their advertising practices. He wrote, “It is our aim to find the mental processes which go on in the minds of the customers from the time they see an advertisement until they have purchased the article advertised” (Gale, 1900, p. 39). Gale discovered that the business community may not have been as interested in psychology as he was in their field; only about 20 businesses returned his questionnaire, a return rate of 10%. In the next five years, however, a theoretical debate among advertisers about the nature of consumer motivation led the advertising community to make contact with psychology, initially with Walter Dill Scott (1869–1955), who published books on the psychology of advertising in 1903 and 1908. With his work, the field of industrial psychology was born (Benjamin, 2004). By 1915, many psychologists were employed full-time in advertising, sales, and human resources.

Thus, while many of the early academic psychologists appeared content to remain in their laboratories, using their new scientific techniques to answer age-old questions of mind, others were lured beyond the ivy-covered walls, motivated by a need for money or a curiosity about problems in the world outside of the academy or by a need to demonstrate the value of the new science of psychology through application. It was the work of those pioneers that marked the beginning of the new profession of psychology, a profession that was to be grounded in science.

THE BEGINNINGS OF THE NEW PROFESSION OF PSYCHOLOGY

It is doubtful that psychologists at the end of the 19th century envisioned anything like the profession of psychology that would exist in the 1930s, much less the profession of today. Yet the earliest of American psychologists, such as William James (1842–1910), G. Stanley Hall, and James McKeen Cattell, clearly recognized the potential contributions of psychology through applied research. It was perhaps only a small step, then, to move from applied research to establishing a role for psychologists as consultants employed outside the university.

The beginning of the 20th century in America was marked by great social upheaval. American cities were growing rapidly and with them the factories that were home to the new urban labor. Immigrants came to America in ever greater numbers, seeking a better life. Child labor laws and compulsory school attendance laws were passed in tandem. These laws were meant to prevent abuses of children in the workplace, but also to provide an education needed for an urban workforce and to impart the values of American society important to the melting pot of fully acculturated citizens. There were movements for a national reform in education and for the right to vote for women. As manufacturing capacity exceeded demand, businesses looked beyond their regions to a national consumer base. Advertising became more important to create those broader markets. The types of jobs available expanded considerably as America moved from a largely agrarian/rural society to an industrial/urban one. Consequently, people sought to better understand the societal and personal impact of one’s job, leading to a new focus—arguably a more scientific one—on adjustment.

The changes in America at the turn of the century virtually clamored for an applied social science to solve the problems of the new society; psychologists both inside and outside of university settings were ready to tackle those problems. We will next examine some of the early practical applications of psychology in business, in counseling, in education, and in clinical settings.

The Business Psychologist

At the beginning of the 20th century, American business was both changing America and being changed by the evolution of American society. With the “formation of large industrial empires came new management problems and a growing problem with efficiency” (Napoli, 1981, p. 28). As efficiency became the watchword of new American business, psychologists would take up the challenges of increasing productivity, improving personnel selection, providing job analyses, and improving worker morale.

Business psychology—later to be called industrial psychology in the 1920s, and then industrial–organizational (I-O) psychology in the 1960s—can be said to have originated with Gale’s advertising study in 1895. But Gale did not pursue that work. Instead, the first sustained program in business psychology was that of Walter Dill Scott, who published many articles on the psychology of advertising.
in *Mahin’s* magazine, a leading journal in the advertising field. Scott also wrote about his advertising work in other magazines, such as *Atlantic Monthly*, *Business World*, *Advertising World*, and *The Woman’s Herald*, thus making business psychology known to a broad audience of potential employers and consumers. Scott promoted the psychology of suggestion, arguing that successful advertising suggested a course of action: that is, buying the product. He wrote, “Man has been called the reasoning animal but he could with greater truthfulness be called the creature of suggestion. He is reasonable, but he is to a greater extent suggestible” (Scott, 1903, p. 59). In applying suggestion to advertising, Scott advocated two techniques: the direct command (e.g., “Use Peterson’s Tooth Powder”) and the return coupon. Both techniques were thought to stimulate compulsive obedience.

In the subsequent theoretical debates in the advertising community on the nature of consumer behavior, other approaches displaced Scott’s views (see Kuna, 1976, 1979), but his work gave psychology considerable visibility in the world of business and paved the way for many psychologists who would follow in advertising, such as Harry Hollingworth, Daniel Starch, and John B. Watson.

Although business psychology can be said to have begun in the field of advertising, it quickly branched into other prominent areas. When increased emphasis on efficiency led to the “scientific management” of Frederick Winslow Taylor (1911), psychologists entered that arena as well. Efficiency meant not only better management and more effective advertising but also better training of workers, improved employee selection procedures, better ways to control employee performance, and better understanding of human actions in work. Prominent in these areas was Harvard psychologist Hugo Münsterberg (1863–1916), who argued in his book *Psychology and Industrial Efficiency* (1913) that the key to workplace efficiency was matching job and worker and that successful matches generated satisfied employees, quality work, and high productivity. Münsterberg promoted psychology as the science of human efficiency, noting that psychology had the tools to create the perfect match by identifying the mental traits required for any job and assessing the mental traits of workers. That his ideas were well received by a broad public is evidenced by the fact that his book was for a time on the national list of best-sellers.

Psychologists began to develop mental tests to evaluate workers and jobs (ship captains, trolley car operators, saleswomen), work that was to prove especially important when they were asked to oversee the selection program for the United States armed forces during World War I. Business psychology had begun in the universities, but its practice soon moved to business settings as psychologists found full-time employment, particularly as personnel officers involved with selection, job analysis, and training. Such opportunities expanded considerably after World War I, establishing the psychologist as a key player in the world of business.

### The Counseling Psychologist

With the proliferation of types of jobs around the turn of the 20th century, people had more occupational choices than ever before. Vocational counseling, which had been a part of the business of 19th-century phrenologists, became even more important. The most influential figure in the vocational guidance movement of the early 20th century was not a psychologist but an individual trained in engineering and law, Frank Parsons (1854–1908). He wrote his most important work in the waning days of his life, a book published after he died, entitled *Choosing a Vocation* (1909). Parsons’s formula for successful guidance involved: (a) a clear understanding of the individual’s talents, limitations, and interests; (b) knowledge about diverse jobs including what was required for success in those jobs; and (c) matching those two kinds of information for the best vocational guidance.

There were clear ties between Parsons’s approach and the sort of matching between jobs and people that was the focus of psychologists in personnel work in businesses. Parsons, as part of the progressive movement of the times, emphasized the reduction of human inefficiency—as reflected in the high turnover of workers—through the application of a careful program of career planning. Vocational guidance became a mantra of progressive reformers and soon found its way into the American mainstream with the formation of the National Vocational Guidance Association in 1913.

Quickly, the vocational guidance counselor was integrated into elementary and secondary schools across America, beginning a strong association between guidance and education. It also made its way into industry through personnel selection. Psychologists found the issues of person and career matching amenable to the new applied science of psychology and worked to develop reliable and valid measures of individual traits and abilities for use in guidance and selection.

Guidance counseling became even more prominent in schools after the passage of the National Vocational Education Act in 1917. Following the First World War, vocational guidance centers (or “clinics,” as they were
36 Psychology as a Profession

sometimes called) were increasingly established at colleges and universities. For example, Witmer founded a separate vocational guidance clinic at the University of Pennsylvania in 1920 that was headed by one of his doctoral graduates, Morris Viteles (1898–1996), who would later distinguish himself as an industrial psychologist.

In all of these vocational guidance centers and clinics, the key component of the arsenal of the guidance specialists was mental tests, including interest tests that were developed in the 1920s, and a growing number of aptitude and ability tests that were used not only in guidance but also for selection. This vocational role, both in personnel work and in guidance, remained relatively stable until after the Second World War. (Baker & Joyce and Koppes Bryan & Vinchur, this volume.)

The School Psychologist

We have already noted that the origins of school psychology lie in the psychological clinic of Lightner Witmer. Thomas Fagan (1992) wrote that:

School psychology was one of many child-saving services originating in the period of 1890 to 1920...[I]t originated in response to compulsory schooling, which provided the stage for development of separate special educational programs for atypical children. School psychology emerged in the middle of the child study movement. (p. 241)

The child study work of Hall focused attention on a broad spectrum of child behavior and education. Many of Hall’s master’s and doctoral students at Clark University worked in what could be described as school psychology, including three particularly influential pioneers: Henry Herbert Goddard (1866–1957), Lewis Terman (1877–1956), and Arnold Gesell (1880–1961).

Goddard was employed at the New Jersey Training School for Feebleminded Girls and Boys in Vineland when he began his research on mental retardation, searching for better tools for intellectual assessment and for methods of effective education and training of mentally handicapped children. Goddard was frustrated in his work at Vineland using the measurement tools he had learned at Clark University and from Cattell’s work. Whereas those tools seemed appropriate for assessment of children of normal intelligence, they were not useful for the children at Vineland. In a 1908 trip to Europe, Goddard learned of a new approach to intelligence testing developed by French psychologist Alfred Binet (1857–1911). Goddard translated the test for English language use; tested it on samples of public schoolchildren, as well as the students at the Vineland Training School; and published his version of the test in 1909. Its popularity as an instrument of intellectual assessment spread rapidly, culminating in the version published by Terman in 1916 that became known as the Stanford–Binet Intelligence Test.

Goddard’s role in school psychology, and more broadly in educational reform, cannot be overstated. He sought to apply the science of psychology to the questions then facing public schools, particularly regarding the educability of children labeled subnormal in intelligence. Through his research efforts, his training workshops for teachers, and the prominence of his ideas in American education, Goddard was instrumental in promoting special education opportunities in American schools (even though many of those efforts went beyond what he would have endorsed). More important for psychology, he established a place for psychologists in the schools as diagnosticians of mental capacity, a role that was often synonymous with the label of school psychologist in the 20th century (Zenderland, 1998).

Terman, like Goddard, also focused on intellectual assessment. Although Terman conducted some research on mentally handicapped children (including some work published with Goddard using subjects at Vineland), his work with children came to be more focused on gifted students, and he is arguably best known (beyond the Stanford–Binet) for the longitudinal studies of children identified as gifted, the “genius studies,” that began in California in 1921. His revision of the Binet test was better psychometrically than Goddard’s across all intellectual levels but especially so in the higher ranges. Terman, like Goddard, enhanced the role of psychologist as assessor of intellectual functioning and as designer of curricula for special-needs children, particularly gifted children.

Gesell was the first person in the United States to hold the title of “school psychologist,” according to Fagan (1992). He was hired by the Connecticut State Board of Education in 1915 to evaluate schoolchildren and make recommendations for those who needed special treatment. Gesell’s duties in the beginning of his work were research oriented, but he later came to be consumed by a caseload of 502 schoolchildren (and his duties were similar to those of contemporary school psychologists). The significance of Gesell’s appointment was that the title “school psychologist” was associated “with services to exceptional children, especially the mentally deficient, and it associated the functions of that title as primarily diagnostic testing for placement decisions in the newly created programs for the handicapped” (Fagan, 1987, p. 406). Although Gesell is perhaps the most prominent of
the early school psychologists, he was not the only person performing those duties in 1915; schools were already employing teachers in intellectual assessment roles and in curriculum design for special children. Norma Estelle Cutts (1892–1988) played such a role as early as 1914 in the New Haven, Connecticut, schools after having worked with Goddard for a year at Vineland (Fagan, 1989). She was one of many individuals whom Goddard influenced to become school psychologists, most of them women who already had teaching experience (Fagan, this volume).

The Clinical Psychologist

At the beginning of the 20th century, psychopathology was the domain of psychiatry and, to a lesser extent, neurology. Psychiatry, arguably the oldest of the medical specialties (excluding surgery), originated with the superintendents of mental asylums at the end of the 18th century. After a half-century of asylum management, the superintendents formed an organization called the Association of Medical Superintendents of American Institutions for the Insane in 1844 and in the same year began publication of their journal, The American Journal of Insanity. The organization’s name was later changed to the American Medico-Psychological Association in 1892, and in 1921 to the American Psychiatric Association; the journal name was changed as well in 1921 to the American Journal of Psychiatry (Grob, 1994). The abnormal mind was of interest to some, perhaps many, of the early psychologists, but the domains of diagnosis and treatment seemed clearly within the boundaries of medicine, and few psychologists saw any need to venture there. That would soon change.

Origins of any field are rarely, if ever, unequivocal—and so it is with clinical psychology. We have already discussed the contributions of Lightner Witmer with respect to school and clinical psychology. Not only did he establish the first psychology clinic in 1896, but as early as 1897 he had described a training program for psychologists to work in a field that he had named “clinical psychology,” a field that would draw from the knowledge base in medicine, education, and psychology (particularly child psychology). An expanded description of this field and a rationale for its further development appeared in the inaugural issue of his journal, The Psychological Clinic (Witmer, 1907), a journal that largely published reports of the cases seen in Witmer’s clinic.

Witmer was clearly interested in the difficulties that children exhibited in the classroom, and believed that psychological science could offer solutions to behavioral problems of perception, learning, motivation, and emotion. He championed the need for accurate diagnosis based on psychological and medical tests—the latter were performed by associated physicians. Slowly, others began to share his vision, and by 1914 there were psychology clinics at 19 universities. Witmer’s focus was on children, and chiefly on problems that impeded learning. Others soon broadened the scope of clinical psychology. However, these early clinical psychologists remained focused on diagnosis and recommendations for treatment, with limited roles in actual treatment until after World War II.

Psychotherapy, a book published in 1909 by Hugo Münsterberg, represents an early psychology-based contribution to the clinical intervention literature. It was a non-Freudian textbook grounded in a theory of psychophysical parallelism, which argued that all psychical processes had a parallel brain process. His volume argued for the scientific study of the processes of psychotherapy and viewed psychotherapy as a clinical endeavor separate from psychiatry.

Other influences came from physicians cognizant of the potential contributions of psychology. Morton Prince (1854–1929) was a neurologist interested in the problems of psychopathology and one who recognized the importance of psychology in the study and treatment of psychological disorders. His most famous book, The Dissociation of a Personality (1908), was a lengthy and insightful description of a case of multiple personality. His contributions to clinical psychology were considerable and include his founding of the Journal of Abnormal Psychology in 1906, which published the early work on experimental psychopathology, and his establishment of the Psychological Clinic at Harvard University in 1926, which he housed in the Department of Philosophy (where psychology was located) rather than in Harvard’s medical school.

Another physician, William Healy (1869–1963), headed the Juvenile Psychopathological Institute, which opened in Chicago in 1909. Healy had studied with William James and had also been influenced by the work of Goddard at Vineland. His institute was to be both a research facility, investigating the causes of juvenile delinquency, and a treatment facility. He hired psychologist Grace Fernald (1879–1966), whom he would later marry. Both Fernald and Bronner used the title “clinical psychologist” and played important roles in research, diagnosis, and treatment. Other juvenile courts and corrections facilities began to hire psychologists for similar roles (Levine & Levine, 1992).
Other stimuli to the development of clinical psychology before World War I included the work on mental assessment by Goddard and other advances in mental testing; the five addresses given by Sigmund Freud (1856–1939) at Clark University in 1909, which fostered considerable interest in psychoanalysis in America but more broadly in the nature of causation in mental illness; the mental hygiene movement initiated around 1908 by former mental patient Clifford Beers (1876–1943) and psychiatrist Adolf Meyer (1866–1950), which sought to understand the early causes of mental illness and how conditions might be changed (in families and society) in order to minimize psychological problems; and the popularity of the Emmanuel movement. The Emmanuel movement was founded by a Wundt doctoral student, Elwood Worcester (1862–1940), in his Boston church. It spread across the United States, emphasizing the alliance of medicine, religion, and psychology in treating mental disorders, and was ultimately credited with the emergence of psychotherapy in America (Caplan, 1998).

All of these forces brought psychology into greater contact with issues of mental pathology and afforded new jobs for psychologists, largely as mental testers. As the demand for these diagnostic services grew, clinical psychologists petitioned the APA in 1915 for a certification program for qualified psychologists in consulting roles, a measure that was seen as protecting the public and preserving the jobs of consulting psychologists. When the APA declined to provide such certification, several psychologists, including J. E. Wallace Wallin (1876–1969) and Leta S. Hollingworth (1886–1939), formed a new organization in 1917 called the American Association of Clinical Psychologists (AACP), arguably the first association of professional psychologists. The membership totaled only about 45 psychologists in its first year — some in university settings, some in applied jobs — and was soon defunct. Although short-lived, the association was a clear harbinger of the coming importance of clinical psychology as one of the field’s applied specialties (Routh, this volume).

WORLD WAR I AND THE GROWTH OF PSYCHOLOGICAL PRACTICE

The foundations for the modern practice of psychology were well in place before the beginning of the First World War. Psychologists could be found working in schools, businesses, hospitals, and social and clinical service agencies. The number of such individuals was still relatively small, particularly in comparison to their colleagues in colleges and universities. Two world wars would dramatically reverse that ratio. The first would promote the rapid development of the practice specialties; the second would open the floodgates for psychological practice, including psychologists as independent practitioners of psychotherapy.

It can be argued that American psychologists were unprepared for World War I. On April 6, 1917, two days after America’s entry into the war, much of the leadership of American psychology — at least those located on the East Coast — were attending the annual meeting of E. B. Titchener’s “experimentalists” at Harvard University (see Boring, 1938, 1967). In attendance was Robert M. Yerkes (1876–1956), who was then president of the APA. Yerkes chaired a discussion about psychology’s role in the war that led to an emergency meeting of the APA Council, called for the end of April. At that meeting, Yerkes established a dozen committees that were charged with pursuing various roles for psychologists within the war effort. Only two of those really materialized. One involved a testing program of nearly two million military recruits, headed by Yerkes, which developed group intelligence tests, namely, the Army Alpha and Army Beta. The second program was headed by Walter Dill Scott, who used his experience in developing job selection tests to assess the job skills of more than three million military personnel, a task accomplished by his staff’s development of more than 100 separate selection instruments in a little more than 12 months. After the war, Scott was awarded the Distinguished Service Medal by the U.S. Army for this monumentally successful program. He was the only psychologist to be so honored in World War I (Napoli, 1981).

The exact number of American psychologists who participated in the war is not known, but the figure is likely between 250 and 300, counting those who served as consultants as well as those in uniform. Toward the end of the war, some were stationed at the 40 U.S. Army hospitals, where their assignments brought them into direct contact with issues of psychopathology. One example was Harry Hollingworth (1880–1956), a faculty member on leave from Barnard College who, as a captain in the army, was working at the army hospital in Plattsburgh, New York, examining approximately 1,200 soldiers suffering from “shell shock” and other psychological disorders. Based on those experiences, Hollingworth wrote a book entitled The Psychology of Functional Neuroses (1920). Although Hollingworth was not led into clinical psychology by his wartime experiences, other psychologists were.
A cataloging of all the activities of psychologists during the war is far beyond the scope of this chapter. What is important to emphasize, though, is that the war efforts by psychologists had important implications for the public and for the discipline of psychology. The work of psychologists, especially in selection, was seen by the government and the public as a program of considerable success. Such favorable press brought many consulting opportunities to psychologists after the war, and psychologists were quick to take advantage of such applied opportunities. For example, Scott founded the Scott Company, a consulting firm of psychologists based in Pittsburgh, to do contract work for businesses and government agencies.

Further, the war work convinced psychologists of the value of their science, that is, that they had something significant to offer in the public sector that was grounded in fact, not myth. This newly gained prominence for psychologists, the public’s perception of the value of psychology as demonstrated by success in the war work, the growing economic prosperity of America in the 1920s, and the rapid social changes in American society after the war were all factors that led to the further development of the profession of psychology.

THE 1920s: THE DECADE OF POPULAR PSYCHOLOGY

American historians have written of the public euphoria in the United States that followed World War I. American forces had helped to win the war in Europe. There was general economic prosperity, and a growing belief in the American dream that anything was possible, with hard work. Writing for the American public in 1925, psychologist John B. Watson (1878–1958) promoted this nurturist optimism:

Give me a dozen healthy infants, well-formed, and my own specified world to bring them up in and I’ll guarantee to take any one at random and train him to become any type of specialist I might select—doctor, lawyer, artist, merchant-chief and, yes, even beggar-man and thief, regardless of his talents, penchants, tendencies, abilities, vocations, and race of his ancestors.

—Watson, 1925, p. 82

Americans seemed delirious with the potential for psychology to improve their lives. The first popular psychology magazines (four of them) began publication in the decade. Countless self-help books were published, and newspapers carried daily columns of psychological advice. Touting the value of psychology for the public, journalist Albert Wiggam (1928) wrote:

Men and women never needed psychology so much as they need it to-day. . . . You cannot achieve these things [effectiveness and happiness] in the fullest measure without the new knowledge of your own mind and personality that the psychologists have given us. (p. 13)

Public demand for psychological services grew rapidly, and consequently, many individuals, with little or no training in psychology, offered their services to the public as psychologists.

Consulting psychologists were especially concerned about such pseudopractitioners, and petitioned the APA to create a certification program to identify psychologists qualified to consult with the public. Initially, the APA balked at the idea, but it relented in 1924, when it established such a program. Four years later, after fewer than 30 psychologists had received certification, the program was abandoned (Sokal, 1982a, 1982b). There was no mechanism for enforcement of such a program, and the public seemed incapable of making distinctions between qualified psychologists and unqualified ones, or at least was uninterested in doing so. Nevertheless, psychology of all kinds prospered—and the professional opportunities in business, school, clinical, and counseling psychology grew at a rapid rate.

STRUGGLES FOR PROFESSIONAL IDENTITY

As early as 1915, consulting psychologists had petitioned the APA to recognize the growth of applied psychology by committing some program time at the annual meeting for discussion of professional issues. But APA leadership had balked, affirming that the APA’s sole stated objective was the advancement of psychology as a science.

When the AACP was founded in 1917, there was concern within the APA that the group would lead to a rupture in organized psychology. In negotiations between the two groups, the AACP agreed to dissolve in 1919 and reorganize as the clinical section of the APA. The clinical section identified three goals: “promoting better working relationships within clinical and within allied fields, developing professional standards for practitioners, and encouraging research and publication on topics in clinical psychology” (Napoli, 1981, p. 26).

Two years later, in 1921, the APA created a second section on consulting psychology, and the short-lived certification program would stem from the efforts of
this group. The consulting/clinical psychologists recommended two additional APA sections, one on educational psychology and the other on industrial psychology, but those two requests were denied.

As the professional opportunities for psychologists grew and as problems in professional practice occurred, these psychologists made additional requests of the APA. They called on the APA to develop a code of professional ethics. They sought help in protecting the label “psychologist.” They called for changes in graduate training that included additional applied psychology experiences, including internships (which had begun as early as 1908 but were still uncommon; see Routh, 2000). And they asked that psychology departments hire more faculty who had significant practical experience. Except for some minimal gestures toward the applied group, the APA largely ignored those requests that were important for the professionalization of psychology, reminding the group of its mantra that the APA was a scientific association.

Throughout the 1920s, more than a dozen applied psychology groups were formed, most of them state associations. The largest of those was the New York State Association of Consulting Psychologists, which began in 1921. By 1930, it was clear to the professional psychologists that the APA was not going to support their efforts. In that year, New York University psychologist Douglas Fryer led a reorganization of the New York group, renamed it the Association of Consulting Psychologists (ACP), and extended its geographic boundaries for membership to include the entire United States. The ACP, thus, became the first “national” association for professional psychologists. In 1933, the ACP published its code of professional ethics, the first such document for psychologists. In 1937, it began publication of the Journal of Consulting Psychology, arguably the first professional psychology journal.

The ACP worked to establish itself as the national association for professional psychologists; nevertheless, it was dominated by New York psychologists. In 1935, a plan was initiated to broaden the ACP membership by creating a federation of societies. All the existing state associations were invited to join, as well as the clinical section of the APA. Eventually, the federation plan was abandoned, and it was decided to create a wholly new organization, the American Association for Applied Psychology (AAAP), which began in 1938. Both the ACP and the clinical section of the APA disbanded and became part of AAAP. The ACP journal was continued by the AAAP as its official organ.

The AAAP began with four sections: clinical, consulting, educational, and industrial psychology. Fryer served as the first president of AAAP and was followed in later years by such important applied psychologists as Walter Van Dyke Bingham (1880–1952) and Carl Rogers (1902–1987). The AAAP’s success was manifested largely through its sections in which psychologists with similar needs could work together on issues of common concern. Each section wrote its own bylaws, elected its own officers, created its own committees, and planned its own program at the annual meeting of the AAAP.

Even though most of the AAAP members retained their memberships in the older APA, many identified more strongly with the new organization than with APA because AAAP provided the professional identity, the collegial relations, and the professional assistance that APA had been unwilling to offer (Benjamin, 1997, p. 728).

Although the AAAP was quite successful in serving the needs of professional psychologists, the organization lasted only slightly more than seven years. Its demise had nothing to do with the service it was providing for the growing profession of psychology. With the United States at war in 1942, there was federal government pressure on the various psychological organizations to come together with one voice for the national good. Negotiations among several groups (including the Society for the Psychological Study of Social Issues, or SPSSI, and the Psychometric Society), principally steered by the two heavyweights, the APA and the AAAP, led to the establishment of a “new” American Psychological Association.

The new APA began with 18 charter divisions, a model borrowed from the sectional structure of the AAAP; a new journal that was intended to be a journal of “professional psychology,” American Psychologist (Benjamin, 1996); and a new central office in Washington, DC (Capshaw, 1999). The new APA also had a new statement of objectives, which read: “to advance psychology as a science, as a profession, and as a means of promoting human welfare” (Wolfle, 1946/1997, p. 721). The “professional” goal had come, of course, from the AAAP, and the “human welfare” goal from the SPSSI. The APA looked and sounded like a new kind of organization, one that had finally acknowledged the presence of the profession of psychology. However, professional psychologists would soon learn that they had little real support (or power) within the new association. It would be almost 30 years before that situation changed in any dramatic way.

POSTWAR GROWTH OF THE PRACTICE OF PSYCHOLOGY

Although American psychologists were caught napping by the First World War, they did not repeat this mistake for
the second one. Both the APA and the AAAP had committees in place by 1939 to plan for psychology’s role should the United States enter the war. As noted earlier, in the first war, psychologists worked largely in two areas: examination of recruits and personnel selection. However, in the Second World War, the involvement of psychologists was substantially more diverse—and it included recruitment, selection, training, equipment design, propaganda, surveying attitudes in the United States and abroad, examining and testing prisoners of war, morale studies, intelligence work, and personality studies, including an analysis of Adolf Hitler (Capshew, 1999; Hoffman, 1992). The verdict on psychologists’ performance in the war was an incredibly favorable one. The legacy of that performance was a growth in scientific and professional opportunities for psychologists unprecedented in psychology’s history. The profession benefited particularly, and no group benefited more than clinical psychology.

Clinical Psychology

Early in the war, the federal government began planning to meet the mental health needs of returning veterans, which were judged to be substantial. Perhaps the government hoped to avoid the hard feelings among veterans that had occurred as a result of their poor treatment following the First World War—feelings that had led to a massive march on Washington, DC. It was evident in 1942 that psychiatrists were too few in number to provide the necessary clinical services, so the federal government mandated that the United States Public Health Service (USPHS) and the Veterans Administration (VA) significantly expand the pool of mental health professionals. That translated into increasing the availability of clinical psychologists.

The USPHS and VA worked with the new APA to expand doctoral training programs in clinical psychology and to identify programs of acceptable quality. The latter goal led to the formation of the APA’s accreditation program for clinical psychology programs in 1946 and one for counseling psychology programs in 1952. The former goal initiated a series of meetings with department heads whose doctoral psychology programs had extant clinical psychology programs or who were interested in developing such programs. The USPHS promised funding to university graduate programs to support clinical psychology students, and the VA promised funding for practica and internship training (Moore, 1992). Because the GI bill had been altered to include benefits for graduate study, money was also available from that program to support doctoral training for veterans, and many chose to pursue advanced study in psychology, with much of that interest directed toward clinical psychology.

Although an accreditation process was already in place within the APA as of 1946, there was no agreed-upon model for clinical training. Discussions of such models dated to the 1890s and a proposal from Witmer. In 1918 and 1919, the APA’s clinical section proffered curriculum and training proposals in a series of articles in the Journal of Applied Psychology, and additional proposals were circulated by the ACP and by the AAAP. As a leader in the AAAP, clinical psychologist David Shakow (1901–1981) was the key figure in drafting a model curriculum for clinical training (see Caution, 2006). He developed a proposal for the AAAP in 1941 that shaped all subsequent discussions, leading to the report of the Committee on Training in Clinical Psychology (CTCP), an APA committee founded in 1946 with Shakow as chair and funded by the VA and the USPHS. The committee’s formidable charge was to (a) formulate a recommended program for training in clinical psychology; (b) formulate standards for institutions giving training in clinical psychology, including both universities and internship and other practice facilities; (c) study and visit institutions giving instruction in clinical psychology and make a detailed report on each institution (Baker & Benjamín, 2000, p. 244).

Shakow and his committee published their report in 1947 (APA, 1947). Two years later, it became the framework for the most famous report in the history of professional training in psychology, the “Boulder Report.” That report was the result of the joint work of 73 individuals from psychology and related fields who came together in Boulder, Colorado, for two weeks in the summer of 1949 to produce a model of clinical training in psychology that became known as the “Boulder model” or “scientist–practitioner model” (Rainy, 1950). The architects of this model argued that it was both possible and desirable to train clinical psychologists as competent practitioners and scientists, a view that continues to be debated today.

Not only was there a new formal model for clinical training, but there was also a new model for the clinical psychologist as practitioner, one that involved training as a psychotherapist, a role for psychologists that was strongly supported by the federal government. Clinical psychologists would break from their tradition in psychometrics to focus on the delivery of psychotherapy. In 1948, the federal government established the National Institute of Mental Health, which gave further impetus to both the training in and practice of clinical psychology (VandenBos, Cummings, & DeLeon, 1992).

The turf disputes with psychiatry had been minor skirmishes before the war, but bigger battles were about to break out as psychologists began to be true competitors to psychiatrists. As the number of psychologists who worked
Examiners was omitted, and currently 13 separate specialty boards exist under the aegis of the parent organization.

Following the conference in Boulder, several other conferences were held to establish training guidelines for a clinical and other professional subspecialties (see Cohen, 1992), but the 1973 Vail Conference affirmed the growing number of doctor of psychology (PsyD) programs in universities and in freestanding professional schools (Korman, 1974). The history of the establishment of professional schools and the PsyD degree has been well documented by Peterson (1992) and Stricker and Cummings (1992). As of March 2011, there were 81 schools that were regionally accredited to offer doctorate degrees in clinical psychology, 63 of which were also accredited by APA. Professional schools now graduate over 50% of new doctorsate in clinical psychology.

Counseling Psychology

As a profession, counseling psychology changed considerably following the war. Vocational guidance remained a duty, but that work would soon shift primarily to guidance counselors within secondary schools (Super, 1955). At the same time, the selection duties that had occupied many in vocational guidance became more exclusively the property of industrial psychologists. In place of these activities, “psychotherapy” came to counseling psychology, initially through the writings and teachings of Carl Rogers, who trained many counseling psychologists after the war in “nondirective” counseling and therapy techniques.

The 1950s proved to be a decade of crisis for counseling psychologists. It was a crisis of identity, or at least role confusion. Counseling psychologists who previously garnered most of their identity as vocational counselors had been called on in increasing numbers to provide a range of services to military veterans in both hospital settings and community service centers. Rehabilitation took on a broader meaning, and in addition to vocational planning, counselors were working on general issues of adjustment with service personnel who sought integration into the general society. Likewise, the role of student personnel workers in higher education began to focus more broadly on student adjustment.

Several clear markers heralded changes for the counseling profession in the 1950s. “Counseling psychology”
became the appellation of choice at the Northwestern Conference of 1951, a meeting specifically organized to explore changes in the field and to make plans for the future. Out of that conference came several initiatives that affected Division 17, the APA, and the VA.

In 1952, Division 17 changed its name from “Counseling and Guidance” to “Counseling Psychology.” The VA established two new psychological job descriptions: counseling psychologist (vocational) and counseling psychologist. In that same year, the APA began accrediting doctoral programs in counseling psychology, partly in response to a doctoral training curriculum recommended by a Division 17 committee (APA, 1952). The final identifying characteristic of a true profession was added in 1954 with the establishment of a new publication, the Journal of Counseling Psychology.

It might seem that counseling psychology had arrived as a profession. Counseling psychologists had an organizational home, a journal, doctoral training programs, and jobs. There were, however, continued difficulties in defining the field that led to a Division 17 Committee on Definition report in 1956 (APA, 1956) and a “crisis” report on counseling psychology as a profession, written in 1960. This latter report was initiated by the APA’s Education and Training (E&T) Board, which appointed a three-person committee to prepare a report on the status of counseling psychology as a professional specialty (Berg, Pepinsky, & Shoben, 1980).

The leadership of Division 17 was not pleased with the unilateral actions of the E&T Board. When the E&T report appeared, the division commissioned its own three-person committee, which drafted a much more optimistic report on the status of counseling psychology, arguing that the profession was thriving, even if graduate programs were not. This 1961 report found that

The rate of growth of counseling psychology has been normal despite limited financial support for the development of graduate programs and the support of graduate students. . . . The social demand for well prepared counseling psychologists is great and continues to increase. The Division of Counseling Psychology has a deep professional obligation to meet this social need.

—Tyler, Tiedeman, & Wrenn, 1980, p. 124

Part of the dissatisfaction within counseling psychology was caused by its comparison with clinical psychology, a profession that was growing at a fantastic rate. By that yardstick, any field would have looked to be in trouble. There was concern from many in counseling that the field should clearly distinguish itself from clinical psychology, whereas others suggested merging the training of the two fields while maintaining differences in the nature of practice.

Traditional work in vocational guidance had been modified by the experiences of counseling psychologists in the VA and work with students in higher education. What emerged was a new specialty area that had as its focus the adjustment of the individual to the demands of everyday life, whether those demands were vocational, educational, or interpersonal. The emphasis on developmental processes of average individuals facing day-to-day life was seen as a clear contrast to the emphasis on psychopathology that was the strong suit of the clinical psychologist.

Industrial Psychology

Other practice specialties also benefited from psychologists’ record of accomplishment during the war. Historian Donald Napoli (1981) wrote this about the postwar growth of industrial psychology:

The military had given psychologists a chance to prove the effectiveness of selection, classification, and aptitude testing, and psychologists met the challenge successfully. Civilian employers also offered new opportunities, which grew largely from the labor shortage produced by wartime mobilization. Business managers, beset by high rates of absenteeism and job turnover, took unprecedented interest in hiring the right worker and keeping him contented on the job. Management turned to psychologists . . . and the amount of psychological testing quickly increased. Surveys show that in 1939 only 14% of businesses were using such tests; in 1947 the proportion rose to 50%, and in 1952, 75%. (p. 138)

Another area of substantial development for the industrial psychologist that grew out of the wartime work was the field of human factors or engineering psychology. The military, in particular, continued to employ psychologists in its research on human–machine interactions, but industry began to employ psychologists to design irons, telephones, arc welders, vending machines, chemical refineries, and the like. Human factors remained an important part of industrial psychology into the 1960s but gradually separated from it, a transition begun in the late 1950s when APA’s Division 21 (Engineering Psychology) and the Human Factors Society were founded. It was ultimately subsumed by psychologists interested in applying social psychological theories to the problems of organizations, leading to the growth of the “O” half of the I-O psychologist.

Prior to the war, most industrial psychologists served as consultants to businesses, thus working part-time as professionals. After the war, however, that pattern changed...
44 Psychology as a Profession

dramatically. Businesses offered full-time employment opportunities, and consequently graduate programs began to train I-O practitioners to fill those jobs.

School Psychology

Unlike other practice specialties, the Second World War had much less impact on the practice of school psychology. Such practice has always been more circumscribed, as the label would imply. Furthermore, whereas the doctoral degree has been assumed to be the minimal level of training necessary for professional practice in the other three specialties, historically most school psychologists have practiced with a master’s degree or specialty credential. Additionally, in the first half of the 20th century, school psychologists came from many different educational backgrounds, sometimes with little actual training in psychology.

Fagan (1990) has divided the history of school psychology into “Hybrid years” (1890–1969) and “Thoroughbred years” (1970 to present). The Hybrid years describe a period when school psychology was “a blend of many kinds of educational and psychological practitioners loosely mobilized around a dominant role of psychoeducational assessment for special class placement” (p. 913). That role still exists in the Thoroughbred years, but the practitioner is more narrowly defined as a school psychologist, typically someone who has a master’s or doctoral degree in school psychology from a nationally accredited program.

The first master’s degree training program for school psychologists was initiated at New York University in 1928, and the first doctoral training program at the University of Illinois in 1953. The APA did not begin accrediting doctoral programs in school psychology until 1971, and accredits only at the doctoral level. Master’s degree programs are accredited by the National Association of School Psychologists (NASP), an organization founded in 1969.

Like the other practice specialties, there have been significant postwar changes for school psychologists as they, too, have struggled to find their identity as a profession (see the report of the Thayer Conference; Cutts, 1955). Still, the Thoroughbred years have been ones of tremendous growth in training and practice for the field. Psychological services in the schools have increased dramatically since the 1970s, in part stimulated by America’s baby boom, but also by federal legislation on education, particularly laws on special education such as the landmark Public Law 94–142, enacted in 1974, which mandated education for all children regardless of handicap.

A “PROFESSIONAL” JOURNAL WITHIN APA

When the new APA was formed in 1946, a “professional” journal was established, American Psychologist (AP). Initially, many articles on professional training and professional job opportunities were published in AP. After 10 years, AP was serving a broader, association-wide role, and the statement about “the professional journal” of psychology was quietly removed in 1957.

It would be 12 more years before practitioners won back a “professional” journal from the APA. In 1966, Donald K. Freedheim was asked by George W. Albee, then president of the Division of Clinical Psychology (12) to edit the newsletter of the division, which was a mimeographed publication. A magazine-like format with a new logo was developed. The format lent itself to having pictures, which enhanced the readability of the publication but also helped to identify authors at conventions. With this new professional-looking publication, the editor invited contributions from members of other service divisions (e.g., school, industrial, counseling), as they were likewise facing issues of standards of practice, training, and licensing that were of concern to the clinical members. Submissions from across the spectrum of professional fields in psychology grew, and there were clearly important issues that all the specialties shared.

The APA had a fine stable of scientific journals at the time but no publication that was appropriate for the sorts of material important to the practicing community—policy issues, case histories, training and internship opportunities, and so forth. It was apparent that a truly professional practice–oriented journal was needed. The APA had just received a large grant from the National Science Foundation to develop new, innovative publications on an experimental basis. “The Clinical Psychologist” was about to be transformed into an “experimental publication” called Professional Psychology (PP), with an editorial board made up of members from across subspecialty fields. The inaugural issue, fall 1969, contained “The Clinical Psychologist,” and the cover of the journal retained the logo that had been developed for the newsletter. By the second issue of the quarterly, “The Clinical Psychologist” was pulled out to be published separately.

The transition from newsletter to journal was not always smooth. “The Clinical Psychologist” had carried book reviews, but none of the APA journals did. All APA-published reviews were in Contemporary Psychology (CP). The PP editor believed it important to retain reviews for both the convenience of the readership and the clear fact that few practice-oriented publications would be
reviewed in CP. After much discussion, the review section was allowed in the new journal, a major exception on the part of the APA Publications and Communications (P&C) Board. A similar, though less crucial, matter came up regarding authors’ pictures, which had seldom appeared in APA journals, except in American Psychologist. Not only were pictures retained in Professional Psychology, but they also started appearing in other APA journals, beginning with Contemporary Psychology. After a year of experimental status, with submissions growing monthly, the quarterly was made an “official” APA publication—and the editor was invited to serve on the Council of Editors.

In 1983, the title of the journal expanded to Professional Psychology: Research and Practice. Professional Psychology is currently published six times a year. During the editorial term of Patrick H. DeLeon (1995–2000), with Gary R. VandenBos serving as the managing editor, Professional Psychology made an even greater effort to address the interests of the practice community. After conducting three reader surveys during the first year, PP readers affirmed that they wanted articles that “provide practical advice and concrete suggestions that could be implemented in everyday practice settings, rather than merely placing the new findings within the context of the existing published literature (and then commenting upon needed future research)” (DeLeon & VandenBos, 2000, p. 595).

Professional Psychology’s coverage included managed care, prescription privileges for psychologists, telehealth care, expanding roles for psychologists within the public policy (including legislative and administrative) arena, and behavioral health-service delivery within primary care, and many of these issues exhibit growing salience for the profession and for the public. In 2007, Training and Education in Professional Psychology, a PP “spin-off” journal, was established by the APA. In 2009, PP was the most-subscribed APA journal.

TWO ASSOCIATIONAL DEVELOPMENTS

Two associational developments in the 1970s and 1980s would expand the reach of psychology into the area of public policy and would enable graduate students in the field to assume a more formalized role within APA governance, respectively.

APA Congressional Science Fellowship Program

Historically, professional psychology had not concerned itself with broad public policy or public health issues (DeLeon, VandenBos, Sammons, & Frank, 1998), but in the 1970s and 1980s, an APA initiative worked to broaden the reach of the field into areas of public policy.

In 1974, Pam Flattau served as the first APA Congressional Science Fellow, under a program established in conjunction with the American Association for the Advancement of Science (AAAS). Nearly 40 years later, over 150 psychologists have served on Capitol Hill or in the administration as APA Fellows, Robert Wood Johnson Health Policy Fellows, or in other similar national programs. These Fellows have included individuals from almost every psychological specialty area, including several who also possessed degrees in law (Fowler, 1996).

APAGS

Prior to the late 1980s, graduate students in psychology had had a limited voice in professional organizations. In 1988, the APA Council of Representatives formally established the American Psychological Association of Graduate Students (APAGS). Over the years, psychology has continued to be an extremely popular undergraduate major. By 2009, total APA membership (including affiliates) had grown to 152,661, with the APAGS members representing approximately one third of total APA membership. An APAGS representative attends the open portions of the APA board of directors meetings (and another individual is seated on the floor of the Council of Representatives as a nonvoting member). Several divisions, state associations, and council caucuses provide the APAGS with a voting seat on their boards of directors.

THE CHANGING ECONOMIC CONTEXT OF THE PSYCHOLOGY PROFESSION

The economic principles of supply and demand, along with the industrialization of health care, provide a framework for understanding important aspects of the psychology profession (Cummings, 2007). Economic principles dictate that if a unit of labor (i.e., provision of psychotherapeutic services) is in short supply, its price increases, and where there is an overabundance, its price decreases. Thus, for example, as Cummings (2007) noted, the higher income of master’s-level nurse practitioners compared to practicing doctoral-level psychologists can be attributed to the fact that there is a shortage of nurses and a glut of psychotherapists, most of the latter at a master’s level who are willing to work for less, competing effectively against
Not coincidentally, the dawn of the professional psychologist during the Second World War took place amid a “seller’s market”—that is, the public’s insatiable demand for psychological services combined with a shortage of trained psychotherapists. Moreover, at this time, third-party payment for psychotherapy did not exist, and as such a free market of checks and balances worked to maintain a relatively efficient market with respect to the doctor–patient relationship (Cummings, 2007).

Further complicating the supply-and-demand relationship is the long-recognized fact that providers have traditionally controlled both the supply and demand sides of the health care equation. That is, the provider determines what treatment is needed and how long it should last. And when the government subsidized the training of mental health service providers (i.e., psychologists, psychiatrists, and social workers) following WWII, it intended to cause a drop in costs as the supply of providers increased. But this did not occur, as providers engaged, albeit unwittingly, in what economists term demand creation, thus nullifying the effects of supply and demand (see Cummings, 2007).

In the 1980s, with the emergence of managed care, health care became industrialized; it would never again be the cottage industry it once was (Cummings, 2007). A dwindling economic base and industrialized health care are realities for the profession of psychology, and together they create a lens through which many current controversies and tensions—intradisciplinary and interdisciplinary—must be understood. An important corollary to the growth of managed care has been the intensifying call for accountability, as mental health care costs increase and payers want assurances that their investments are paying off. Moreover, as Bickman (1999) noted, “a major effect of managed care was the direct attack on the clinician’s autonomy or ability to decide what care a client should receive…. Clinicians were at a great disadvantage because they had few data about the effectiveness of the services they delivered” (p. 966). Such economic and societal pressures have provided additional motivation to demonstrate empirically the differential effectiveness of various treatments (see also Salzer, 1999). The meaning and relevance of the results of such empirical studies, including the precise definition of “evidence” (Tanenbaum, 2005), have been sources of intradisciplinary tension within the profession of psychology, particularly within clinical psychology. These tensions reflect a long-standing divide within clinical psychology, often referred to as the scientist–practitioner gap.

**PSYCHOLOGY PRACTICE AND INTRADISCIPLINARY TENSIONS**

The scientist-practitioner gap reflects long-standing intradisciplinary tensions rooted in epistemological differences. Strengthened by social and economic forces, these tensions are manifest by ongoing controversies regarding the most appropriate treatments and training models, as well as in numerous attempts to narrow the scientist-practitioner gap.

**The Scientist–Practitioner Gap**

The scientist–practitioner gap refers to differing stances among psychologists regarding the core on which clinical practice should be based, resulting in intradisciplinary tensions. With greater emphasis on the need for empirically supported treatment approaches, there has been disagreement over how best to interpret and utilize psychotherapy research (Lilienfeld, Lynn, Namy, & Woolf, 2009). The divide between science and practice greatly increased in the 1980s and early 1990s, in response to the recovered memory controversy, during which disagreements surfaced over the validity of what came to be known as “recovered memories,” or long-forgotten memories that resurface during or following psychotherapy (Cautin, 2011a). Many psychologists tended to regard these memories as likely inaccurate and perhaps unwittingly generated by well-intentioned clinicians.

The recovered memory controversy was not an isolated incident. The roots of the scientist–practitioner gap reach back to practitioners’ early struggles to find organizational support, and to the epistemological differences revealed through the discipline’s struggles with psychoanalysis (see Hornstein, 1992). Although both academic psychology and psychoanalysis each considered their own endeavors scientific, each possessed different epistemologies that rendered them seemingly incompatible: whereas academic psychology derives its knowledge from laboratory studies, psychoanalysis relies instead on the clinician’s experience and subjective interpretation. As much as the academic psychologist wanted to eschew discussions of psychoanalysis, the public’s fascination with Freud and his ideas made such discussion unavoidable. Consequently, many academic psychologists co-opted psychoanalytic concepts...
and terms, and ultimately translated these ideas into behaviorist language (Hornstein, 1992).

In many ways, the Boulder model of training in clinical psychology represented an ecumenical call for the integration of science and practice. But the model’s intention notwithstanding, these intradisciplinary tensions continued throughout the 20th century and persist today. Rooted in long-standing epistemological differences and propelled by changing economic and societal pressures, they are visible today in wrangling over the most appropriate treatments, the most suitable model of training, and in persistent efforts to bridge, or at least narrow, the scientist–practitioner gap.

**Empirically Supported Treatments (ESTs)**

Prior to the 1990s there were no specific guidelines for practitioners when choosing among myriad psychological treatments for various psychological problems. Since the early 1990s, however, clinical psychologists have formed numerous task forces to address this shortfall. These efforts have been inspired by the mismatch between the growing body of scientific research on psychotherapy and the nominal impact it has had on actual clinical practice (Herbert, 2003). Further, there has been an increasing demand for clinicians to provide interventions that are substantiated by research (Nathan, 2004). In 1993, for example, the Division (now Society) of Clinical Psychology (Division 12 of the APA), under the leadership of then-president David Barlow, convened the Task Force on Promotion and Dissemination of Psychological Procedures, which was charged with “considering issues in the dissemination of psychological treatments of known efficacy” (Chambless & Ollendick, 2001). Its first report (Task Force, 1995), delineated selection criteria for ESTs and a preliminary list of treatments that met these criteria; subsequent reports expanded this list (1996, 1998).

In 1999, the Task Force became a standing committee of Division 12, the Committee on Science and Practice, whose task it remains to continually evaluate the efficacy and effectiveness of psychological interventions (Chambless & Ollendick, 2001). The committee continues to identify, develop, and disseminate information about ESTs, and to ensure the training of clinicians in these treatments (Calhoun, Moras, Pilkonis, & Rehm, 1998; Sanderson, 2003), providing for the psychological community what could arguably be called its first formalized standard of care (Sanderson, 2003).

But the effort to identify ESTs has generated fierce debate. Critics of the EST movement maintain that it: (a) disenfranchises therapeutic approaches that are nondirective and not symptom focused (Bohart, O’Hara, & Leitner, 1998; Fensterheim & Raw, 1996; Messer & Wampold, 2002; (b) is misguided because nonspecific factors, as opposed to particular techniques, are largely responsible for therapeutic gains (Elkins, 2007; Garfield, 1998); (c) minimizes the importance of patient and therapist variables in therapeutic outcomes (Garfield, 1998); (d) minimizes the key role of clinical judgment (Levant, 2004; Peterson, 2004); and (e) relies on overly restrictive methodological criteria, including an overly narrow definition of evidence, and relies on treatment manuals, both of which severely restrict the generalizability of results to actual clinical settings (Albon & Marci, 2004; Goldfried & Eubanks-Carter, 2004; Seligman & Levant, 1998). Moreover, some critics possess a principled opposition to the very notion of ESTs. Some of this philosophical opposition is based on the notion that “lists of ESTs reflect a political or theoretical bias more than they reflect treatments that work” (see Woody, Weisz, & McLean, 2005, p. 11), while some is based on the view that the EST movement is “an erosion of their autonomy as professionals due to pressure to conduct ESTs,” which is seen as “too rigid and objectifying rather than humanizing clients” (p. 11).

Even among those sympathetic to the EST movement, some have criticized the overall effort in terms of the soundness of the science on which it is based. For example, while affirming the important role the EST movement can play in bridging the scientist–practitioner gap, Herbert (2003) urges substantial changes in the procedures used for identifying ESTs, including eschewing the use of the no-treatment baseline as a basis for comparison, establishing procedures for removing treatments from the list, and determining clear guidelines for differentiating treatment procedures.

In the face of claims regarding the disenfranchise-
ment of nondirective therapies and the potential inhibi-
tion of innovation of new psychotherapeutic interventions, Nathan (2004) insists, “the positives of evidence-based practice for professional psychology far outweigh the negatives” (p. 217). Most importantly, Nathan explains, such practice guidelines reduce the chances that well-intentioned therapists will inadvertently harm patients in their effort to help them (see Lilienfeld, 2007). He further contends that:

> From the perspective of the marketplace as it interacts with public policy, it also appears to be the case that professionals whose assessment and treatment methods are based largely on
48 Psychology as a Profession

empirical evidence are likely to enjoy greater public acceptance and public support, with one result likely being eventual parity in reimbursement for professional psychologists and another being greater public openness to the expansion of professional psychology practice, including prescription privileges. (p. 218)

Regardless of one’s views on the issues, the debate regarding the wisdom of the EST movement and the widening of the scientist–practitioner gap continue unabated (e.g., Stewart & Chambless, 2007), carrying with them significant implications for the field, including for the issue of training.

A New Training Model and Accreditation System

The tensions in clinical psychology, engendered by the growing scientist–practitioner gap, are also reflected in the ongoing emergence of alternative training models. Since the inception of modern clinical psychology in the mid-20th century, the scientist–practitioner model of training (Rainy, 1950)—with its explicit call for the integration of science and practice—has been the dominant training paradigm (Norcross, Karpia & Santoro, 2005). But the Boulder model was not without its critics; and alternative models soon emerged, first in the late 1960s with the scholar–practitioner model, with the ascendance of the professional school movement, and most recently in the mid-1990s, with the creation of the Academy of Psychological Clinical Science (APCS) and the clinical scientist model of training.

According to McFall (2002), the Boulder model of training fostered an illusion of unity among doctoral training programs. In reality, the model provided an umbrella under which programs that varied widely in their commitment to integration and in their relative emphasis on scientific research and clinical practice were treated as legitimate and equivalent. All illusions were shattered, however, once the professional schools dared to offer professional-only training [in accordance with the scholar–practitioner model of training]. (p. 664)

Reflecting the divisive nature of the field of clinical psychology, the newly founded APCS proposed a third alternative training model—clinical science—in which research is of prime importance (McFall, 2006). According to the APCS’s mission statement:

“Clinical science” is defined as a psychological science directed at the promotion of adaptive functioning; at the assessment, understanding, amelioration, and prevention of human problems in behavior, affect, cognition, or health; and at the application of knowledge in ways consistent with scientific evidence.

—McFall, 2006, p. 35

The discussion of appropriate training models is not simply academic, for different models yield different outcomes (McFall, 2006). Indeed, even proponents of the professional school movement have voiced concerns about its quality control (Peterson, 1996, 2003).

The question of quality control bears direct relevance to the issue of accreditation. Most clinical psychology training programs, regardless of the model to which they subscribe, are APA accredited. In the view of Baker, McFall, & Shoham (2008), the APA accreditation system is ineffectual because “it will not be a lever to hoist the quality of clinical training programs, and it certainly has not prevented a slide in quality” (p. 85). It has been criticized for the very fact that heterogeneous programs are awarded the same stamp of approval, rendering it impossible “to differentiate between clinicians who were trained scientifically and those who were not” (p. 86). To attempt such differentiation, in 2007 the APCS inaugurated the Psychological Clinical Science Accreditation System (PCSAS), which “brand[ed] a new type of clinical psychology, one that is designated as psychological clinical science” (p. 87). The PCSAS awarded its first accreditation to the University of Illinois at Urbana-Champaign in November 2009 (“New Accreditation System,” 2010).

The new accreditation system proposed by the PCSAS has elicited much criticism and protest from within the psychological community. Steven Breckler and Cynthia Belar of the APA, for example, maintained that contrary to Baker et al. (2008), the APA accreditation criteria assert “education and training in the scientific foundations of psychological practice, including training in empirically supported procedures, is critical regardless of training model” (Breckler & Belar, 2010). Others sympathetic to the rationale behind the new accreditation system nevertheless argue that such a change would work at cross-purposes, serving to widen rather than narrow the scientist–practitioner gap: “The proposed new accreditation system would overemphasize scientific production within doctoral programs with a minimal emphasis on clinical training in much the same way that the current system often overemphasizes clinical training with minimal emphasis on science” (Gardner, 2010). Cautioning that the proposed new system would exclude virtually all PsyD programs from achieving accreditation, Gardner advised that “any new accreditation system (or modification of the current system) should focus on correcting the science–practice divide that has resulted in a dearth
of scientifically informed practitioners of professional psychology, and not on the establishment of what would essentially be accredited doctoral programs of research” (Gardner, 2010).

**Current Efforts to Bridge the Gap**

Aware of the need to address this intradisciplinary divide, many psychologists continue to work to bridge the gap. Two current projects are worth mentioning in this regard, each designed to address the challenges inherent in translating psychotherapy research into practice (DeAngelis, 2010). Division 12 (Clinical Psychology) of the APA, under the leadership of its president, Marvin Goldfried, is administering an online survey in which practitioners are asked to relate problems they have faced practicing empirically supported treatments. A committee of Division 12 will then collate the findings and circulate them to the clinical psychology community, researchers and practitioners. According to Thomas Ollendick of Virginia Tech, “the survey could be the start of a trend toward more accurately understanding and addressing practitioner concerns” (DeAngelis, 2010, p. 42).

Another project, known as the Pennsylvania Psychological Association Practice Research Network (PPA-PRN), seeks to actively involve private practitioners in the design and execution of studies on psychotherapy process research (Borkovec, Echemendia, Ragusea, & Ruiz, 2001). In one of its recent studies (Castonguay et al., 2010), almost 1,500 therapeutic events, described and rated independently by actual clients and their therapists as being either helpful or hindering, were gathered and then coded by three independent observers. Findings indicated that among the most helpful interventions were those that increased clients’ self-awareness. According to Louis Castonguay, current chair of the PPA-PRN, “Many therapists were pleased with the fact that they were able to use data from client reports to immediately improve on their work” (as cited in DeAngelis, 2010, p. 42). The success of such unifying efforts has important implications for professional psychology as a whole; particularly given the increased call for accountability by external sources and the desire to influence health-care policy and practice (Barlow, 2004).

**PSYCHOLOGY PRACTICE AND INTERDISCIPLINARY TENSIONS**

Traditionally, the scope of activity for the professional psychologist was to a large extent restricted to psychometric work, while psychotherapy was considered the exclusive domain of the psychiatrist (Cautin, 2011b). But, increasingly, encouraged by the support of the federal government following WWII, practicing psychologists pushed the boundaries of their field, conducting psychotherapy and entering into private practice. In fact, although it was not the intention of the framers of the Boulder model (Rainy, 1950), psychotherapy increasingly became the chief activity of the professional psychologist over the ensuing decades (Garfield, 1981). Not surprisingly, this trend was accompanied by increasingly bitter tensions between psychology and psychiatry (see Buchanan, 2003). Psychology’s hard-won indicators of professionalism—including licensure; certification; and, later, freedom-of-choice legislation—were achieved with the goal of ensuring greater professional status, legal recognition, and economic viability for the field. This was crucial to psychologists in the face of psychiatry’s opposition and concommitant legal efforts to retain its prior dominion over the practice of psychotherapy.

Along with changes in the economics of the profession, the field of psychology continues to encounter interdisciplinary tensions as professional boundaries are challenged. Relevant to this discussion are two potentially significant developments: psychologists’ efforts to gain prescriptive privileges (known as the RxP agenda), and the increasing number of nonmedical and master’s-level mental health practitioners.

**Prescriptive Authority (RxP) Agenda**

The quest for psychology’s prescriptive authority (RxP), or the right for licensed psychologists to administer and prescribe medications in the service of their patients, dates back to the 1970s, when the APA board of directors had appointed a special committee to review the issue. Its recommendation was to not pursue prescription privileges, largely owing to the fact that the field was thriving (DeLeon, Sammons, & Fox, 2000). The pursuit of prescriptive privileges was reignited in November 1984, when Senator Daniel K. Inouye addressed the annual meeting of the Hawaii Psychological Association. He suggested that a new legislative agenda—prescription privileges for psychologists—would fit nicely into the theme of their convention, “Psychology in the 80s: Transcending Traditional Boundaries.” In response to his challenge, the executive committee of the Hawaii Psychological Association agreed to pursue such legislation, although there was little enthusiasm for the proposal within the psychological community and fierce opposition within the local psychiatric community (DeLeon, Fox, & Graham, 1991).
In 1989, the APA Board of Professional Affairs (BPA) held a special retreat to discuss the issue of prescription privileges, and consequently recommended that a feasibility study be conducted to explore the issue. The BPA further recommended that the issue of prescription privileges be made the APA’s highest priority. At the APA annual convention in Boston in 1990, the motion to establish an ad hoc Task Force on Psychopharmacology was approved by a vote of 118 to 2. This task force was charged with exploring the advisability and feasibility of such privileges and with determining what training would be entailed. In its 1992 report to APA Council, the task force concluded that practitioners with combined training in psychopharmacology and psychosocial treatments could be viewed as a new form of health care professional, one expected to bring to health care delivery the best of both psychological and pharmacological knowledge (Smyer et al., 1993). As others have noted (e.g., Fox et al., 2009), conflicts and controversies notwithstanding (see Stuart & Heiby, 2007), the subsequent decade witnessed significant progress in establishing a solid base for psychology’s pursuit of prescriptive privileges, both within the APA and in the public domain.

Relevant here is the historical connection between the APA and the Department of Defense (DoD), which initiated a congressionally mandated psychopharmacology fellowship training program in the early 1990s, pursuant to the fiscal year 1989 appropriations bill for the Department of Defense (P.L. 100–463) (U.S. Department of Defense, 1988). In June 1994, the program graduated the first two of what would ultimately be 10 psychologists, and the subsequent success of the program suggested that professional psychologists could be trained to provide high-quality and patient-centered psychopharmacological care (Newman, Phelps, Sammons, Dunivin, & Cullen, 2000).

At its August 1995 meeting, the APA Council of Representatives formally endorsed prescriptive privileges for appropriately trained psychologists, calling for the development of model legislation and a model training curriculum, both of which were endorsed the following year. The training curriculum consisted of a minimum of 300 didactic contact hours in five core content areas, and supervised medical treatment of at least 100 patients in both outpatient and inpatient settings (Newman et al., 2000). In 1997, the APAGS adopted a “resolution of support” for the APA position regarding psychology’s prescriptive authority, and during that same year the APA Council authorized the APA College of Professional Psychology to develop an examination in psychopharmacology for use by state and provincial licensing boards. By 2009, about 208 psychologists had taken the exam following the prescribed program. The Association of State and Provincial Psychology Boards (ASPPB) has no formal position regarding prescriptive authority, but it has developed guidelines for its membership to consider as their legislatures enact RxP bills (ASPPB, 2001; Newman et al., 2000). At its August 2009 meeting, the Council updated its model licensing and training standards, pursuant to the recommendations of a joint Board of Educational Affairs–Committee for the Advancement of Professional Practice (BEA-CAPP) task force. The Council approved as a measure of quality assurance the establishment of an APA designation program, which would serve as a mechanism for identifying psychopharmacological training programs that meet APA guidelines. As of 2010, such training programs exist at Alliant International University, Fairleigh Dickinson University, New Mexico State University, and Nova Southeastern University; approximately 1,500 psychologists have completed the prescribed training. In recent years, several training programs have been established that focus on the training of psychologists already in practice, including the Prescribing Psychologists Register, which increasingly utilizes distance learning and intensive training modules. As of fall 2010, 276 graduates have been admitted to take the psychopharmacology licensing exam, which historically has a passing rate of about 71%.

At the same time that the prescriptive authority movement has gained momentum, including the APA’s incorporation of the American Society for the Advancement of Pharmacotherapy as its 55th Division (Stuart & Heiby, 2007), arguments have been leveled against the movement. Among the many criticisms raised, opponents cite the increasing use of psychotropic medication and the simultaneous decreasing utilization of psychotherapy. They argue against an overreliance on psychotropic medications, and maintain that such an expansion of psychologists’ practice may lead to a decrease in time devoted to psychotherapy. Moreover, others argue that psychologists, owing to “relative deficits in training and experience related to managing medications . . . are likely to be more vulnerable to lawsuits when inevitable adverse outcomes occur” (Stuart & Heiby, 2007, p. 26). And still others warn against the negative ramifications such privileges would have for the field of psychology as a whole (e.g., Albee, 2005).

Internal and external resistance notwithstanding, there have been slow and steady legislative advancements at the state level with respect to the prescriptive authority (DeLeon, Robinson-Kurpius, & Sexton, 2001; DeLeon & Wiggins, 1996; Fox et al., 2009). Currently, two states—New Mexico (in 2002) and Louisiana (in
2004)—have achieved prescriptive authority, and passage of such legislation in some other states has been close. In February 2010, for example, both houses of the Oregon legislature passed relevant the statutes, but the Oregon governor vetoed them 2 months later. While no comprehensive bill has yet passed, in 2001 the U.S. territory of Guam passed legislation authorizing appropriately trained psychologists to prescribe in the context of a collaborative practice arrangement with a physician. According to Fox et al. (2009):

The prescription privileges movement has reached a tipping point—the story is no longer about the 10 psychologists training to prescribe by the DoD Psychopharmacological Demonstration Project. The story is now about the psychologists prescribing in the civilian sector, whose numbers continue to grow and will likely exceed 100 in the near future.

Indeed, over the years approximately 37 state associations have established task forces to coordinate RxP activities, with 24 states having introduced relevant legislation since 1985.

Master’s-Level Practitioners

Another source of tension—both intradisciplinary and interdisciplinary—stems from the ever-increasing number of master’s-level psychotherapists, including psychologists, social workers, licensed professional counselors, and marriage and family therapists, who are available to meet the increasing demand for mental health services (Robiner, 2006). Moreover, managed care networks employ far more master’s-level practitioners than doctoral-level ones, and since the former are willing to work for less money, reimbursement schedules are set accordingly (Cummings & O’Donohue, 2008). Indeed, research indicates that master’s-level psychologists are just as effective as their doctoral-level counterparts. Nevertheless, many psychologists continue to argue for the superior competence of psychologists trained at the doctoral level. How the field of psychology manages the realities of the dynamic mental health workforce will have significant implications for the future of professional psychology—in terms of defining roles and responsibilities, developing training models, and interdisciplinary collaboration.

THE 21ST CENTURY

Unquestionably, the psychological practice environment will continue to evolve dramatically throughout the 21st century. The specifics of change are, of course, unpredictable, but certainly the expanding role of computer and telecommunications technology in the delivery of clinical services is under way. In 2001, the Institute of Medicine, which has served as a highly respected health policy “think tank” for administrations and the Congress since its inception in 1970, reported:

Health care delivery has been relatively untouched by the revolution in information technology that has been transforming nearly every other aspect of society. The majority of patient and clinician encounters take place for purposes of exchanging clinical information... Yet it is estimated that only a small fraction of physicians offer e-mail interaction, a simple and convenient tool for efficient communication, to their patients.

—Institute of Medicine, 2001, p. 15

But the past decade has witnessed an upsurge in the systematic investigation and clinical use of technology in the delivery of clinical services (Jerome et al., 2000). Although some negative attitudes toward “tele-health” exist within the field (e.g., Reese & Stone, 2005), increasingly researchers and practitioners alike are exploring ways in which access to mental health services—including assessment, diagnosis, intervention, and supervision—can be improved. Kazdin and Blase (2011) argue that in addition to the prevailing individual psychotherapy model, additional models of service delivery are needed in order to reduce rates and costs associated with mental illness, broadly defined. Among several models delineated, they illustrate how technology confers on the public opportunities to reduce the burden of mental illness by increasing dramatically the ability to reach individuals in need. Web-based interventions, telephone-administered psychotherapy, and particular smartphone applications are examples cited by Kazdin and Blase to illustrate the burgeoning use of technologies in expanding access to mental health services. Given today’s realities of managed care (Cummings & O’Donohue, 2008), ever-advancing technology, and a growing need for psychological services (Kazdin & Blase, 2011), professional psychology will likely need to engage strategically and with recognition of other disciplines, in order to ensure the viability of its future.

REFERENCES

52 Psychology as a Profession


References 53
Psychology as a Profession


