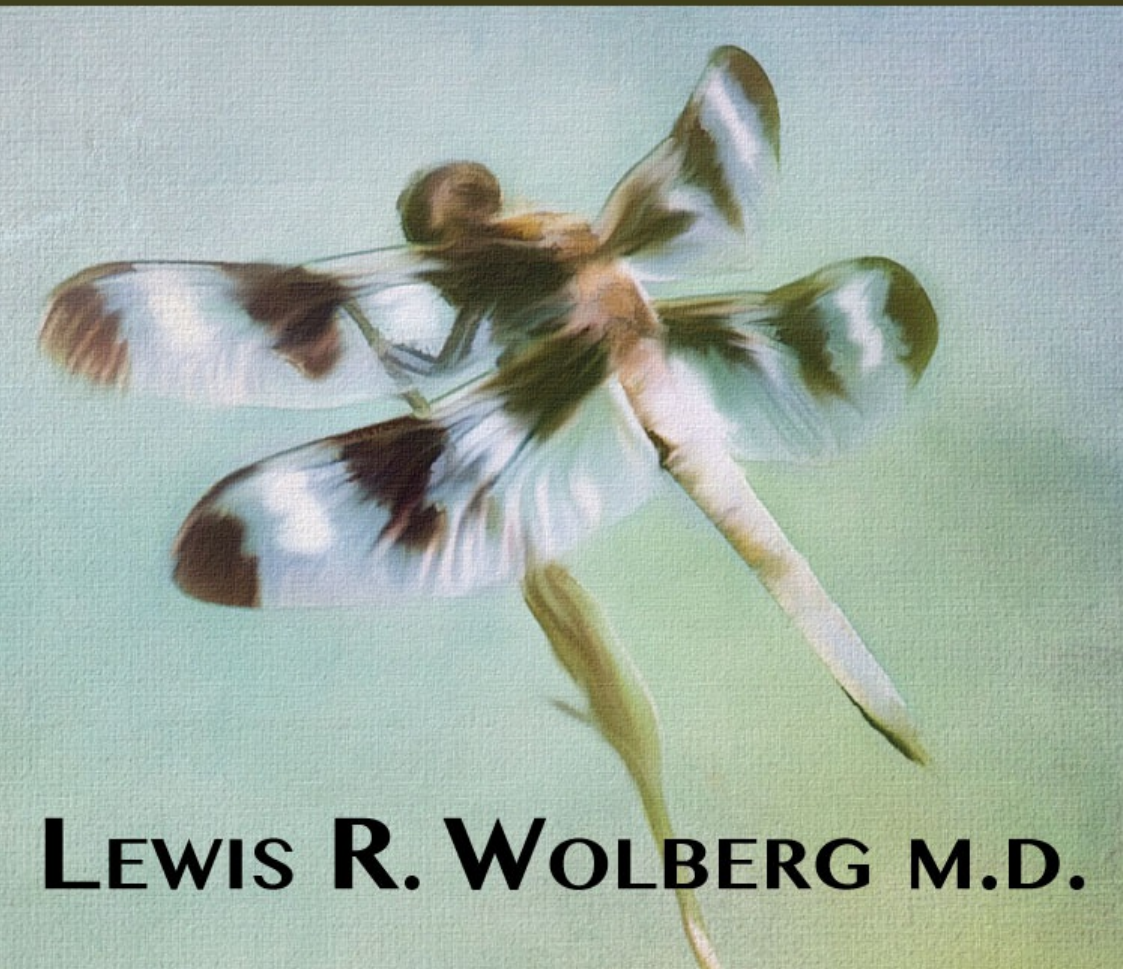
THE TECHNIQUE OF PSYCHOTHERAPY

WHO CAN DO PSYCHOTHERAPY?



LEWIS R. WOLBERG M.D.

Who Can Do Psychotherapy?

Lewis R. Wolberg, M.D.

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Who Can Do Psychotherapy?

With the advent of third-party payments for psychiatric services, the question of who can and should do psychotherapy has become a burning issue. Economic and political factors are influencing opinions about professional competence. The experience of the past decades has convincingly proven that individuals from a number of disciplines who have had adequate postgraduate training and supervision and who possess personalities capable of establishing and maintaining empathic and insightful relationships are capable of doing good psychotherapy.

Unfortunately, there are difficulties in defining what constitutes psychotherapy and no fixed regulations governing qualifications of a therapist. Almost anybody can set himself or herself up as a counselor, or psychotherapist, or guidance expert. What obscures the issues is that any contract between two people is potentially reassuring and comforting, temporary relief being forthcoming on the basis of the placebo effect and other non-specific agencies irrespective of the validity of the treatment maneuvers. The greater the charisma of the "healers" the more dogmatic their allegations, the more rhapsodic are the testimonials of devotees who flock to them for help. Nor are those hopeful devotees always untutored or ignorant. Even the sophisticated and educated possess a covert yearning for magic, hoping that a new entry into the therapeutic arena will bring forth a miracle cure.

Efforts to introduce legislation to control the practice of psychotherapy have not proven too successful, not only because of the lobbying and political efforts on the part of groups potentially threatened, but also because members of the established professions cannot agree among themselves regarding standards of education and practice.

Further complicating the muddle is the fact that an emotionally disturbed person often does not realize the emotional roots of his or her problem and actively seeks out a professional other than a psychotherapist, like a physician, teacher, minister, lawyer, marital counselor, or social worker, particularly when the complaint is focused on physical, educational, marital, interpersonal, or social difficulties. The urgency of the problems imposed on such professionals has forced many of them to evolve ways of handling people in distress, largely oriented around advice giving and active

interference in manifest environmental disorders.

There is little question, no matter how deftly we employ semantics or how we distort words, that some of these techniques are psychotherapeutic in effect, if not process, since they involve the setting up of a relationship with the goal of modifying symptoms or correcting personality blocks. The exigency of community need, coupled with the lack of any other resource to which people in trouble might turn for help, has thus propelled many professionals who have had no training in psychotherapy into a therapeutic role. As Galdston (1950) has commented, "Parent, priest, minister, teacher, faculty advisor, social worker, marriage counselor, vocational adviser: all of them in different ways, indulge in psychotherapeutic gestures. They are in effect lay psychotherapists; have been such for centuries past and are bound to continue as such for a long time to come."

This situation, unfortunately, has proved itself to be not an unmixed blessing, for the great majority of such professionals are not equipped by education, disposition, or experience to do psychotherapy. While they may be able to function in an advisory or friendship role, they do not have the basic knowledge or the skill to handle the patient on a therapeutic footing.

This is not to say that individuals with emotional problems do not improve in the course of professional relationships with people untrained in therapeutic techniques. Offering a sympathetic, reassuring relationship to individuals in trouble may be of great help to them and, if they are not too ill, may suffice to restore their equilibrium. Even sick, schizophrenic patients often do better with a humane and tolerant helping person rather than with a trained therapist who lacks certain interpersonal traits (Castelnuovo-Tedesco et al, 1971). Helpful as it may prove to be, however, a relationship alone is not sufficient for adequate psychotherapeutic process. Psychotherapeutic skills require much more than supplying a patient with friendship. When an untrained person begins to act as a psychotherapist, and particularly where he or she delves into conflicts, defenses, and resistances, serious difficulties may ensue, the relationship becoming explosive in charges of transference and countertransference. The individual may even find his or her own neurosis interlocking with that of the other person until he or she is unable to extricate himself or herself from the relationship without creating a dangerous crisis in the life of the individual with whom there has become hopeless involvement.

The realization that emotional difficulties are ubiquitous has lent force to an educational movement among professionals whose task it is to handle people in trouble. The aim of such training is enabling the professional to differentiate emotional problems from other problems and to manage the former on some kind of correctional level. The chief professionals involved have been psychiatrists, clinical psychologists, and psychiatric social workers. In addition, increasing numbers of nonpsychiatric physicians, nurses, ministers, educators and an undifferentiated group of nonprofessional mental health aids or paraprofessionals are also being recruited as helpers or adjuncts. While there is general acknowledgment of the need for mental health services and recognition of the shortage of trained psychotherapists in supplying the community needs, a wide spectrum of opinion is reflected regarding who and what to train.

THE PSYCHIATRIST IN PSYCHOTHERAPY

The role of the psychiatrist in psychotherapy is becoming increasingly blurred with entry into the field of a growing number of psychologists, social workers, educators and miscellaneous clinical counselors. Valiantly defending their position as guardians of the medical tradition are societies of medical psychoanalysts and psychotherapists who restrict membership in their organizations and carry on disputations with the unwelcome hordes of intruders desiring entrance into areas they consider their personal domain. The inability to stem the invasion is largely due to lack of legal definition of what constitutes the difference between verbal interchanges conducted under medical as contrasted with non-medical auspices. The argument that the great need for psychotherapeutic services cannot be supplied by psychiatrists alone is still considered by many medical people as insufficient grounds for sponsoring persons they consider incompetent to diagnose, prescribe, or to treat mentally disturbed patients irrespective of postgraduate training in psychotherapy. Non-medical people believe that the basic source of the quarrel is purely economic, coupled with a need to retain superior status and privilege. It has nothing to do with competence in functioning as providers in mental health. They resent the restrictions the psychiatric profession seeks to impose on their activities especially in regard to third party payments and hospital privileges.

Because “historically, morally, ethically, popularly, and legally, society and patients have always given the ultimate responsibility for patient-care to the licensed medically trained physician” (Dickel,

1966), medicine has assumed the attitude that persons suffering from all forms of emotional difficulties fall within its domain. However, recognition that the medical model is not pertinent for all emotional problems has resulted in greater cooperativeness with other professionals.

New trends in medical education may be forecast that will affect the training of psychiatrists. Both the Association of Medical Colleges and the AMA Council on Medical Education have issued statements to the effect that the undergraduate period of medical education does not prepare a student for independent medical practice without supplementation by a graduate training program. Ideally, undergraduate medical education should foster and encourage the specific interests of each student by tailoring the program to his or her needs. Adoption of these ideas will necessitate a more flexible course curriculum. Moreover, the traditional general internship is being questioned as a requirement. The Mills Report (1971) recommends abandonment of the internship as a separate portion and the combination with the residency into a single period of medical education. Pressures are mounting to reduce undergraduate medical education to a 3-year instead of 4-year span. This plan has already been adopted by a considerable number of medical schools.

The tremendous advances in the behavioral and biological sciences are such that it is not possible to prepare students for specialization in psychiatry within the restricted time of traditional medical education. One of the handicaps of the medical people who wish to pursue a psychiatric career is that they have concentrated on medical subjects during their school years that have relatively little relationship to their functioning in the mental health field. This focus has occurred to the neglect of subjects dealing with social and cultural content, which are highly pertinent to human adaptation. This is not to depreciate the value of a medical background, particularly in areas such as neurophysiology, biochemistry, and other topics that deal with the biological aspects of behavior. On the other hand, the medical information essential for a career of surgery, orthopedics, and other specialties may not be essential for a psychiatrist. Would it then not be better to institute a special program, weighted on the side of the behavioral sciences, during the last half of schooling in medical school? A positive answer to this question has already been put in practice in a new curriculum instituted at Pennsylvania, Einstein, Duke, and Yale medical schools (Lidz, 1970).

A traditional background tends to fixate the psychiatrist on a medical model of mental disorders

and to overstress biological development and physiological homeostasis as the core agencies in personality disorders. Interpersonal relationships, group dynamics, and cultural factors become of secondary importance if they are acknowledged at all.

Recommended is a distinctive type of specialization in psychiatry that still has its foundations in medicine. A balance of subjects in the behavioral science field would enable the psychiatrist to cope more adequately with clinical and social aspects of mental health. One plan focuses the 18 months on the basic sciences and the "bridging courses" that prepare for clinical experience, i.e., physical diagnosis, laboratory diagnosis, history taking, pathology, psychopathology, and interviewing. Lecturers are replaced by specially prepared or selected readings, clinical presentations, and seminar discussions; and audiovisual tapes are employed. By the end of the fifth semester the students complete all required clinical clerkships in internal medicine, pediatrics, surgery, obstetrics and gynecology, and psychiatry. The last 18 months of medical school are planned for elective work involving a special "track" corresponding to goals and interests and involving clinical work and further intensive work in the basic sciences (such as biochemistry and cellular biology). For students preparing for psychiatry the last 3 semesters integrate the course work in the behavioral sciences (including neurobehavioral sciences and work in psychopharmacology) with a variety of supervised clinical experiences in a psychiatric hospital, general hospital, and community mental health agencies. Planned are a personal therapeutic experience, perhaps group therapy, and a research project under a tutor or supervisor.

Lidz (1970) writes:

> On the completion of this program, the student will have reasonable familiarity with (1) psychodynamic and psychoanalytic theory and personality development; (2) the neurobehavioral sciences and psychopharmacology, both at a theoretic and practical level; (3) various psychologies of potential pertinence to the field such as the work of Piaget, operant conditioning, learning theory, dissonance theory, and psycholinguistics; (4) the foundations of sociology, social psychology, and ethnology; (5) techniques and attitudes required for interviewing patients; (6) the various psychiatric syndromes; (7) various types of therapy that will enable him to function as a resident from the start of his residency training.

Another change is the abolishment of the internship in a field or fields other than psychiatry, instituting instead a psychiatric internship. Liberation of the physician who intends to specialize in psychiatry from the medical courses and internship experiences that only remotely relate to future practice will, it is hoped, provide more time to delve into the behavioral sciences and humanities that are

more congenial with educational needs. It will permit the student to acquire a firmer grounding in the theories and practices directly related to psychotherapy.

A trend coming into prominence that may affect the psychiatrist in future years, is the demonstration of the maintenance of professional competence through recertification every few years (U.S. DHEW, 1971). The American Boards of Family Practice, Internal Medicine, and Plastic Surgery are already committed to recertification. In psychiatry voluntary self-assessment programs are being sponsored by national organizations, such as the American Psychiatric Association, and continuing education programs have been required in some states as a prerequisite to relicensing.

What goes into the making of present-day psychiatrists will vary with the opportunities available to them. After medical internship and residency the physician usually becomes associated with a mental institution or with the psychiatric division of a large hospital. To qualify for certification in psychiatry, 3 years of institutional experience are required as well as an additional 2 years of practice in the psychiatric field. Having given evidence of varied experience in adult and child psychiatry, the psychiatric candidate is examined in the areas of psychiatric and neurologic diagnosis, neuroanatomy, neurophysiology, neuropathology, psychodynamics and the various psychiatric therapies. If the examination is successful, the candidate is awarded a certificate of specialization as a Diplomate of the American Board of Psychiatry and Neurology.

During the training period the physician usually learns principles of diagnosis, somatic therapy, community psychiatry, and psychotherapy. Experience in the latter is obtained through supervised work in outpatient departments. The quality of this training will depend upon the teaching and supervisory staff. Hospitals connected with medical schools generally are staffed by therapists skilled in various kinds of psychotherapy, including psychoanalysis, group therapy, behavior therapy, short-term therapy, hypnosis, etc. Obviously, the thoroughness of training will depend on the motivation of the student to learn and the quality of available instruction.

Not as many psychiatrists as in former years seek further formal analytic postgraduate training after completing their residency. Attacks levied on psychoanalysis by both its friends and foes, the long period of training required for analytic specialization, the high cost of personal psychoanalysis, available

lucrative positions in community psychiatric clinics, and opportunities for early private practice without further postgraduate work have reduced the percentage of psychiatrists seeking further training in the specialty of psychoanalysis. This involves application to and acceptance by a psychoanalytic school. The content of this instruction consists of several years of didactic lectures and seminars in dynamic psychiatry, clinical conferences, and case discussions, a personal psychoanalysis, and the handling of several psychoanalytic cases under supervision. Some psychiatrists attempt to learn the technique of psychoanalytic therapy in a less formal way without matriculating, by taking open courses in psychoanalytic theory, by reading the psychoanalytic literature, by entering into personal psychoanalysis or psychoanalytic psychotherapy with a trained psychoanalyst, and by carrying one or more cases under supervision of an analyst. How successful this less disciplined form of training will turn out to be is largely dependent on the caliber of the psychiatrist. Understandably, the psychiatrist who elects such training is under a greater handicap than one who is enrolled in a regular analytic school and is exposed to a formal course of instruction.

Some objection is expressed to the overweighting of the significance of training in psychoanalysis at the expense of other behavioral sciences. There is a feeling that "psychoanalysis while initially a liberating influence in freeing psychiatry from a purely phenomenologic orientation has in turn had stultifying effects on evaluation of psychiatric thinking. Its stimulation of comprehensiveness had led to premature closure in some circuits." (Barton & Malamud, 1964).

The continuing shortage in psychiatric manpower has focused attention on why the proportion of medical students entering psychiatry has diminished. A number of reasons have been given for this (Pardes, 1979). First, psychiatry does not enjoy the prestige of some of the other specialities. Second, the quality of psychiatric teaching in medical schools has not been inspiring, especially where teaching is relegated to younger, less experienced, less prestigious members of the staff who are not considered the best of role models. Third, controversy among the teachers and supervisors as to which form of psychotherapy is most valid, and disagreements about theory do not lend to psychiatry the scientific warrant possessed by other branches of medicine. Fourth, strained relations between psychiatrists and other physicians, and derision heaped upon the personalities and activities of professionals in the mental health field have a bad influence on the student struggling with choices of his future field of practice. Fifth, a most important influence, is probably economic; psychiatrists rank low on the income

scale of the specialities. Moreover postgraduate training in postgraduate institutes of psychoanalysis and psychotherapy require more time and money than the resident can afford, having accumulated a sizeable debt during his graduate training years.

All of these factors contribute to a psychiatric manpower shortage, which for a while was abated by acceptance of foreign medical school graduates in hospitals, clinics, and training centers. For example at one time in the State of New Jersey, 90 percent of the psychiatric residents were foreign graduates. National legislation in the mid 1970s, however, restricted the inflow of foreigners, which left a gap unfilled to this day. The encouragement by the government through funding grants for training of primary care physicians and family practitioners has taken away an important pool of potential psychiatric trainees. The influx into the field of psychotherapy of large numbers of clinical psychologists, social workers, psychiatric nurses, and paraprofessionals has also had an effect through the blurring of roles in the choice of psychiatry as a profession. Many young medical aspirants are sensitive to such jibes as the definition of a psychiatrist as "a social worker who prescribes drugs."

Continuing changes of federal and public priorities as well as altering concepts of psychiatric practice have a deadening effect on the supply of psychiatrists to service public need. Psychiatrists are now in such short supply, according to the President's Commission, that two-thirds of the counties in the United States do not have a single psychiatrist. (Roche Report: Frontiers of Psychiatry, Nov. 1981).

In recent years there have been strong attacks on psychiatry and psychiatrists by the press. Such criticism is eagerly utilized by enemies of psychiatry to discredit the profession as a whole. Some medical groups believe that involvement with social problems has caused psychiatrists to dissociate themselves from medicine. On the other hand there are those who believe that psychiatrists are too biologically oriented and not sufficiently conversant with social pathology, issues of politics, economics, law, and how they affect the mind and emotions. The psychiatrist is, therefore, pulled in two directions: first, toward rapprochement and greater identification with medicine, and second, toward involvement with psychosocial factors that are important in disease and the maintenance of health. A compromise enabling the psychiatrist to straddle this identity crisis is to practice what is called "behavioral medicine" which is another way of saying that comprehensive, holistic, "compleat" services are provided. A unification with medicine is also being encouraged by liaison consultation work with primary physicians and specialists.

Advances in biological psychiatry have encouraged biological research that is better regarded than vague forays into social areas.

Whether these factors will decrease the prevailing shortage of psychiatrists is not at all certain. Economics will undoubtedly play a most important part. At the present time there are few monetary incentives for entering psychiatric specialization. Surveys reveal that compared to all other specialties, psychiatrists are near the bottom end of the earned income scale. Moreover, a smaller number of well paying private patients now exist due to fierce competition by a variety of trained and untrained providers who are willing to work at relatively low hourly rates. Psychologists, social workers, psychiatric nurses, and others are increasingly being employed by Health Maintenance Organizations and insurers at a fee below what is ordinarily paid psychiatrists. These are some of the reasons why the percentage of medical students drawn to psychiatry have fallen from 11 percent to less than half that proportion producing a critical shortage of psychiatrists. The lure of the other high-paying specialties is too tempting to correct the imbalance. As research in the biological aspects of psychiatry has elevated the importance of biochemical and neurophysiological vectors, more and more medical school graduates are applying for psychiatric residencies aiming for careers in biological psychiatry. A sentiment is developing in a number of circles that ultimately psychiatrists will concentrate their activities in helping with biological interventions seriously ill patients while relegating the less seriously ill to non-medical workers for psychotherapeutic care.

THE CLINICAL PSYCHOLOGIST IN PSYCHOTHERAPY

Clinical psychology has come a long way in establishing and legitimizing itself as a primary mental health discipline. To this end, licensing laws for psychology are in effect in most states. The aim of such licensing laws is to create a measure of accountability on the part of practicing psychologists and to consider consumer protection a worthy responsibility of psychological service. Eligibility for licensing generally includes the Ph.D. degree in psychology, supervised predoctoral internship, postdoctural work, and a state examination. This procedure is currently implemented in most parts of the country. Furthermore, since psychology has been included in some health insurance programs as an independent mental health profession, requirements for licensing have become more uniform on a national scale. In addition to licensing the title of “psychologist,” laws are now being drafted that define the function of a

psychologist. This recognition of function will ensure that the practice of psychotherapy becomes better regulated so that consumer protection will finally emerge as a major concern of the mental health professions.

The increasing acceptance of the clinical psychologist as an independent mental health professional has in the past decade led to a vast broadening of new responsibilities assumed by the psychologist. For example, clinical psychologists are now being asked to share chief decision-making positions in mental hospitals. It is no longer uncommon to find clinical psychologists in charge of admission and treatment wards in hospitals. Psychologists are beginning to design treatment programs and many clinics have psychologists on their staffs conducting both individual and group psychotherapy. Thus the clinical psychologist has emerged as an independent mental health worker, capable of providing the entire range of mental health services from consultation to psychotherapy, from diagnostic specialist to clinic director. Clinical psychologists serve on a multitude of governmental advisory boards, act as judicial consultants, function on faculties of medical schools and law agencies, and serve on community action boards.

Clinical psychology, therefore, has evolved into an autonomous, self regulating profession with psychotherapy as one of its integral operations. Though the function of psychotherapy itself is not licensed, the practice and title of psychology is now regulated by the 50 States and the District of Columbia. With a current membership of over 50,000, the American Psychological Association (A.P.A.) has supported a National Register of Health Service Providers in Psychology to furnish public and other referral sources with a listing of those who have (1) State Licenses, (2) a doctoral degree from an accredited university, and (3) two years of supervised experience in a health service in clinical psychology, of which one year is in an organized health service training program and one year at post doctoral. The term “clinical” is in fact gradually being replaced with the title “health service provider” in psychology, defined as a psychologist who is certified/ licensed at the independent practice level in his/her state, who is duly trained and experienced in the delivery of direct, preventive, assessment and therapeutic intervention services to individuals whose growth, adjustment or function is actually impaired or is demonstrably at high risk of impairment. (National Register, 1983) Thus, psychology as a profession has become part of the larger health delivery system in the United States. At this time the majority of members of the American Psychological Association are in some form of clinical practice

including counseling, industrial/organizational activity, and psychological services in schools. Current estimates indicate that over 25,000 psychologists are licensed in the various states.

Within the American Psychological Association the movement toward the professionalization of psychology took its major organizational leap in 1948, after World War II, when the Division of Clinical Psychology started. It was not until twenty years later, in 1968, when those clinicians specializing in psychotherapy organized the A.P.A. Division of Psychotherapy. A further specialized organization came in 1980 with the inauguration of the Division of Psychoanalysis, and most recently, in 1982 when pragmatic concerns about issues of private practice led to the formation of the Division of Independent Private Practice. A new Division of Health Psychology is also attracting a large membership. With the self-regulatory evolution of the profession, both standards for practice as well as ethical principles were developed. The A.P.A. Standards for Providers of Psychological Services (1977) promoted the "quality, effectiveness and accessibility of service to all who require them." They also specify the minimum acceptable levels of quality assurance and performance that these providers must reach or exceed. These standards address the issues of public responsibility and accountability. Similarly, the A.P.A. Code of Ethics (revised, 1981) has continued to professionalize psychology, and acceptance of membership in the A.P.A. is considered a commitment to these ethical principles. These include detailed references to responsibility, competence, moral and legal standards, public communications, confidentiality, patient welfare, and professional relationships, as well as research with human participants.

With the tightening of its internal organization, the field of clinical psychology has been rapidly developing into diversified areas. The direction of this vigorous growth of professional psychology has been largely dictated by social, legislative, as well as economic forces. For example, the current concern with cost containment is the impetus for the expansion of short-term therapy methods. The stretching and broadening of its boundaries indicates that "clinical psychologists are becoming involved in anything and everything that involves human behavior in its normal and abnormal forms." (Edelstein & Brasted, 1983). This has become most evident in the National Register (1983) with its listings of multiple frames of references as well as the variety of both general and specific services offered. According to the Register Guidelines, registrants may identify up to three theoretical orientations in order of performance from among the following: behavioral, eclectic, existential-humanistic. Gestalt, interpersonal relationship, psychoanalytic, rational emotive/cognitive, reality, Rogerian, client-centered,

social learning, and systems-oriented. Also, registrants may list up to three service approaches in order of preference from among the following: consultation, couples therapy, diagnosis, family therapy, general practice, group therapy, and individual therapy. Furthermore, five specified services are chosen in order of preference from among the following: biofeedback, child abuse and and spouse abuse therapy, disability determination, forensic services, hypnosis, learning disabilities, marital therapy, neuropsychology, pain management, physical illness/disability, play therapy, psychodrama, rehabilitation, sexual dysfunction therapy, stress management, substance abuse, and women's issues.

As a part of its professionalization, the formal doctoral training programs as well as the internships in clinical psychology are now periodically reviewed and accredited by the A.P. A. These generally consist of a minimum of three academic years of fulltime resident graduate study. Instruction in scientific and professional ethics and standards, research design and methodology, statistics, psychological measurement, history, and systems of psychology are included in every doctoral program in professional psychology. Each student is required to demonstrate competence in each of the following substantive content areas: (1) biological bases of behavior (e.g., physiological psychology, comparative psychology, neuropsychology, sensation, psychopharmacology; (2) cognitive-affective bases of behavior (e.g., social psychology, cultural, ethnic and group processes, sex roles, organizational and systems theory); and (3) individual behavior (e.g., personality theory, human development, individual differences, and abnormal psychology). Virtually all doctoral programs require students to attend four years of full-time internship. These internships are also subject to accreditation standards by A.P.A. in areas of assessment, research, and therapeutic competence. After attaining a Ph.D. or Psy. D. (about 4 percent of the doctoral programs now offer the Doctor of Psychology degree) many clinical psychology students seek further training in psychotherapy when completing their internship, despite having focused heavily on treatment, personality theory, psychodiagnosis, and field experience during their graduate work. Many students have enrolled in the school of Carl Rogers in Chicago for training in client centered therapy.

Another major development in postdoctoral training has been the appearance of experiential-Gestalt training institutes as well as non-psychodynamic behavior therapy institutes. As a matter of interest, there has been a great upsurge of such schools, and some clinical psychology doctoral programs offer exclusive training in behavior modification psychology. Clinical psychology is becoming so "innovative" and technique-oriented that proponents of different treatment philosophies sometimes

appear to be tearing asunder the psychologist-professional-scientist model. Instead of considering the Ph.D. training as a scholarly and scientific study of principles of behavior, there are those psychologists who would consider philosophical differences sufficient to warrant the overthrow of psychodynamic psychology and the creation of new fields of psychology based upon parochial interests.

In late years there has, nevertheless, occurred a keen interest in psychoanalysis. In the past only a few postdoctoral institutes, which offered training in psychodynamic psychology, would accept psychologists. Since the early to mid 1960s, however, a plethora of training institutes have been started that accept psychologists. Theodore Reik's National Psychological Association for Psychoanalysis in New York City originally had two popular postdoctoral training centers for psychologists. Other postdoctoral interdisciplinary institutes include the Postgraduate Center for Mental Health and the William Alanson White School for Psychiatry, Psychoanalysis, and Psychology, both in New York City. Apart from offering a Certificate in Psychotherapy and Psychoanalysis following the completion of four years of training, the Postgraduate Center provides specialty psychotherapy training opportunities utilizing groups with children and adolescents, with families, and in the supervision of the therapeutic process. In all these programs, psychologists are involved in administration, teaching, and supervision.

Since the mid 1960s other more orthodox psychoanalytic postdoctoral institutes have begun admitting psychologists. In addition, throughout the country new postdoctoral institutes have been created and developed exclusively to deal with the ever increasing demand of psychologists for psychotherapy training. These include the program for postdoctoral study and research in psychology at New York University, the postdoctoral psychotherapy center of the Institute of Advanced Psychological Studies at Adelphi University, and a number of smaller unaffiliated institutes in and around New York. Furthermore, psychologists who have been trained in psychoanalysis and who are identified as both psychologists and psychoanalysts are currently teaching in most psychoanalytic institutes.

Future trends in psychotherapeutic practice suggest both increased diversification and specialization. One of the most popular current areas attracting huge numbers of psychologists is in behavioral medicine or health psychology. With more profound recognition of psychosocial factors in physical problems, psychologists are contributing to resolving emotional conflict as a major source of physical or medical symptoms. Gentry (1981) has defined medical psychology as "the application of the

concepts and methods of normal and abnormal psychology to medical problems." It refers to the cooperative effort between behavioral scientists and medical practitioners in the diagnosis, treatment, and prevention of physical illness and reflects an acceptance of the importance of psychosocial factors in part or in whole to aspects of physical illness." Another area in which the demand for services is enormously greater (almost 80 percent according to Vandenbos, 1979) than supply is in clinical child psychology.

Other specialties include community psychology with its social systems level intervention, clinical gerontology, clinical neuropsychology, and rehabilitation psychology. The field of family and marital therapy is also growing enormously. The deepening involvement of clinical psychologists in mental health and psychotherapy has resulted in the publication of a substantial number of articles and books regarding both theory, process, and outcome of treatment. Earlier publications include those of C. R. Rogers (1947-1951), Thorne (1950), and Glad (1959) and more recent books those of London (1964), Shapiro (1965), Singer (1965), Stieper and Wiener (1965), Beier (1966), Wollman (1967), and Zucker (1967). Other contributions of the psychologist to mental health have been comprehensively reviewed by Rennie and Woodward (1948), Lester (1964), and Howard and Olinsky (1972). In addition, contributions by psychologists such as Erich Fromm, Rollo May, David Rappaport, and Roy Schafer have examined the nature of personality, helping to expand the understanding of the psychotherapeutic process. Some of the more significant books by psychologists that have influenced theoretical and clinical thinking during the past decade include those by G. Klein (1976), Schafer (1976), Wachtel (1977, 1981), Smith, Glass & Miller (1980), Stolorow & Lachmann (1980), Garfield and Bergin (1978), Epstein & Feiner (1979), Strupp & Hadley (1978), Spence (1982), and Atwood and Stolorow (1984). The new A.P.A. Divisions of Psychotherapy and Psychoanalysis both currently print quarterly journals that publish the best contribution of psychologists in this field.

The claim that psychologists have regarding their singular qualifications as psychotherapists lies in their graduate education in psychosocial and research areas that have a bearing on the therapeutic process. Interest in learning theory and development has brought forth many contributions by psychologists in biofeedback, behavior modification, personality development, humanistic approaches, outcome research, and other areas of the field.

In addition to having extensive involvement in the development and practice of new techniques, clinical psychologists have utilized traditional modalities of treatment, including individual and group work, family therapy, systems theory work (Jackson, 1959; Haley, 1968), hypnosis (Gill & Brenman, 1959), and marathon (Mintz, 1971). Also, as a psychotherapist, the clinical psychologist is in a unique position to be involved in clinical investigation on a research level, such as research on motivation for treatment (Krause, 1966, 1967), personal attraction in psychotherapy (Goldstein, AP, 1962, 1971), goals of treatment (Hill, JA, 1969), client variables in treatment (Garfield, 1971), the development of instruments measuring emotionality (Plutchik & Kellerman, 1974), and the motives of therapists (Henry, Sims, & Spray, 1971).

Although this is less than in previous years the increasing differences in clinical practice have contributed to criticism from segments of the psychonomic experimentalists who would rather see clinical psychology excised from scientific psychology. As more candidates have entered the field of clinical psychology, academic psychologists have on occasion reacted unfavorably. Clinicians are regarded, more or less, as renegades from science. Their interest in personality theory, it is claimed, is in defiance of the more precise structure of the experimental approach. Further claims are made that clinicians are geared toward the questionable pragmatism that if a tactic helps a patient, it should be employed irrespective of all its empirical virtuosity and that the use of tests that may be invalid is defended against all logic. Polygraphs and computers should constitute the armamentarium of the scientist, not ink blots. Learning theory is a more suitable companion for the psychologist than psychoanalytic theory. Research, not interviewing, is the psychological matrix. Clinicians, considered inferior mates, find that their marriage to the academicians stands in great jeopardy. Indeed, there are some psychologists who believe that clinical activities should be abandoned by psychology and left entirely to the field of psychiatry. The illicit love affair that clinical psychologists are carrying on with psychiatrists, say these critics, acts against the good name of the profession as a whole. To resolve this situation, a divorce action has been recommended by some, with a splitting of the psychological field into two and the administering of a new degree, Doctor of Psychology, to the clinicians (Henderson, (1966). There are those who object to this move “to sweep an unwanted progeny under the carpet.” On the other hand, there are others who, insisting that sound experimental training does not necessarily produce a competent professional psychologist, believe that a new degree can provide “a broad yet intensive

program that emphasizes interdisciplinary training, practical problem-solving in real life settings, and a sophisticated knowledge of how to use research findings without the necessary condition of producing original research" (Wright, MW, 1966). The new degree may help to resolve the antagonism that "has arisen as a result of two different kinds of people, researchers and practitioners, sharing the same degree."

As the identity concerns of the psychologist regarding legitimacy are put to rest, psychologists are evaluating more and more the extent to which they may or may not be maximizing or even properly utilizing their particular contribution.

THE SOCIAL WORKER IN PSYCHOTHERAPY

Social workers, like other professionals, are searching for new roles and values that will bring them into step with the temper of the times. There has been a tremendous increase in social work education at every level. Social work has also achieved increasing governmental recognition as a profession. Some form of licensing, certification, or registration for social workers is required in many states, and professional societies are working toward such laws in states that now do not possess them.

Among the specialties in social work of greatest pertinence to helping people in trouble to cope with external factors that sabotage adaptation, is social casework. Typically, for at least the last 60 years, social casework has been an adjunctive service in a so-called "secondary" setting: an agency such as a school, hospital, or clinic where casework is not the primary function.[1] The range of agencies where casework is utilized is far too wide to be described, but a few typical casework positions could be mentioned: medical settings where the caseworker has the responsibility of helping the family deal with the financial and emotional blows of hospitalization and aid in discharge planning, adoption and fostercare agencies where caseworkers supervise the selection and supervision of foster homes and the emotional adjustment of children to the homes, public assistance agencies where caseworkers oversee both financial assessment and rehabilitative planning, and child guidance clinics and family service agencies where caseworkers have the primary direct treatment responsibility. The fact that casework is typically practiced in a secondary setting naturally opens up all of the problems common to any professional team, such as issues of professional status and jealousy, divisions of responsibility, and so

forth.

In spite of years of theoretical debate and various attempts at systematization, there has never been achieved a generally agreed-on theory of casework, and more than ever, there is disagreement as to what actually constitutes casework. In a real sense a history of casework is a history of debates, of theoretical swings of the pendulum.

The psychoanalytic treatment of "shell-shock" victims of World War I exposed casework, as it did much of the rest of the world, to the work of Freud and his followers. Within a few years the new psychoanalytic principles swept the field of casework, and even relief agencies tried to deal with the emotional aspects of financial assistance. For the first time there was a meaningful explanation of the refusal of clients to follow the treatment plan laid out by the agency—it was "resistance." In an extreme swing of the pendulum, casework became suffused and dominated by psychoanalytic principles. But again, the swing was too extreme and problems arose. Many of the clients had pressing and overwhelming social and financial problems that brought them to the agencies; they were much less concerned about their unresolved Oedipal feelings. Still, the psychoanalytic movement of the 1920s added much to the overall and ongoing body of casework knowledge.

The next great shift in casework practices was brought on by the Great Depression of 1929. The overwhelming social needs of people affected by the Depression made psychoanalytically oriented casework a luxury that few could afford. Skills had to be developed in helping clients, through short-term services, to meet overwhelming economic catastrophe. The Social Security Act of 1935 brought the great expansion of the federal government into the field of social welfare. Many social workers moved to the newly developing public assistance agencies from the mental hygiene agencies, which were beginning to close down.

The psychoanalytic principles of the 1920s were not being totally rejected; they were being modified by the overwhelming social needs of the 1930s and by a reaction against the mechanistic and deterministic orientation of pre-ego-psychology psychoanalysis. The will therapy of Otto Rank, who was teaching at the University of Pennsylvania School of Social Work, had great influence on the faculty, particularly, Jessie Taft and Virginia Robinson. In 1930 Virginia Robinson published the book that was to

usher in the great schism of Functional vs. Diagnostic: *A Changing Psychology in Social Casework.* The appeal of the functional point of view and its difference from the psychoanalytic, which was now called diagnostic casework, was that people were not helpless motes to be buffeted about by wild instincts and unsettled economics. They possessed qualities of responsibility and creativeness that caseworkers could help release. The agency and worker could provide a stable base offering the client specific services within a set time for utilizing relationship in engaging the client to make and act on choices and decisions.

The conflict of ideologies still exists, with modifications, but it has moved on to include a struggle between other viewpoints. There are caseworkers influenced by sociological contributions to small-group development and community forces, drawing particularly from the work of Georg Simmel, Charles Cooley, Kurt Lewin, and Ronald Lippitt. There are those who believe that general systems theory, which conceptualizes interfaces between individuals, families, social groups, and communities, encompasses the impact of stresses on clients and helps make their casework practices more viable. Others are influenced by the existential "humanistic" approach, which accents strife in overcoming obstacles to self-development. Crisis theory and communication theory have their followers, as has learning theory, which has recently been added to the repertoire of interventions used by social workers, and behavior modification methods, particularly in dealing with problems such as juvenile delinquency, drug addiction, and psychotic mental illness. We might say that psychiatric social workers operate with a succession of models—from the medical-disease model (Richmond, 1917; Hamilton, 1941; Hollis, 1974) to a functional mode (Taft, 1948, to an eclectic problem-solving model (Perlman, 1957) to a behavioral model (Thomas, EJ, 1970; Thomas, DR, et al, 1968).

Between 1972 and 1976 the number of students in graduate schools of social work who concentrated on casework declined from 85 percent to 36 percent. This does not entirely indicate a loss of interest in therapeutic practice. Combined or generic programs of study are attracting the largest group of students and are perhaps bettei designed to equip graduates for the rapidly changing functions of agencies. For example, a sizable number of agencies have shifted from programs focused on casework to those related to community problems and social action, including “advocacy.”

Advocacy in social work has a long tradition, social workers being identified as those championing

the causes of the neglected population. In recent years it has attracted a more militant group of workers who fight for social benefits of the underprivileged as rights to be provided by government rather than gifts of noblesse oblige. The aim has been not only for improvement of service programs, such as child care, medical care, housing, employment, education, and recreation, but specifically in relation to psychological needs. Because clients have been helpless in claiming their rights, social workers have taken up the cudgel for them in cutting through the bureaucracy and contradictory legal procedures that stymied the beneficiary from getting help. Cooperation between social workers, lawyers, and clients has resulted in legal actions against public agencies not living up to their assigned function. These actions have served to bring about changes in service systems and other social institutions within existing resources and structures. Because public opinion may tend to oppose socialized or welfare state solutions for problems, social worker advocates foster the creation of constituencies that can press for new social reforms (Grosser, 1973).

These directions do not detract from the need for casework since the problems that originally initiated its development still exist and require management. Because interpersonal involvement with the client draws upon processes akin to those of psychotherapy, caseworkers in practice often find themselves functioning as psychotherapists. This role for greatest effectiveness requires more sophisticated postgraduate training than caseworkers can acquire in their customary work in agencies. More and more social workers interested in the mental health field are accordingly entering into postgraduate psychotherapeutic and psychoanalytic training programs. Facilities for such training are relatively limited, but they will undoubtedly become more extensive as the need arises. For example, at the Postgraduate Center for Mental Health in New York City, postgraduate programs open to qualified social workers include psychoanalysis and psychotherapy, child psychiatry, group therapy, family therapy, and community mental health consultation.

The social worker as a psychoanalyst or psychotherapist is gaining increased acceptance. In 1968 California became the first state to pass a law under which there is a specific category of "clinical social workers" who are licensed to practice psychotherapy. There is a strong movement for a similar law in New York. A small group of social workers started The Society of Clinical Social Workers in New York City in 1968. It is now a national organization with chapters in many states and a sizable national membership of approximately 1500. This represents a movement of some significance since it was only

1955 that social workers united in a national organization after years of being split into such separate work-focused groups. Clinical social workers are attempting to establish their identity distinctive from the general family of social workers, arguing that there is a great dissimilarity in training and services, and they have lobbied for licensing laws that are designed specifically for their functions. As independent workers who have involved themselves more and more in therapeutic areas, some groups have attempted to incorporate the word "psychotherapy" in their title. For example, the Texas Society for Clinical Social Work changed its name to Texas Society for Social Psychotherapy. The chief reason given for the change was that the title helped to define and regulate their own area of competence as differentiated from social workers in community organization and welfare work, from social service technicians, and from social service aids. The question of competence of the members of the clinical social worker group, of course, will be dependent on the quality of their postgraduate training.

While clinical social work has been defined by the NASW Register of Clinical Social Workers as involving "diagnostic, preventive, developmental, supportive, and rehabilitative service to individuals, families and/or groups whose functioning is threatened or affected by social and psychological stress or health impairment" or practiced in a range of settings such as schools, family agencies, mental hospitals, and community mental health centers, the workers entering private practice have grown exponentially as interest in the traditional functions of casework has declined. Golton (1971) points out that for many years private practitioners were unable to get professional recognition and practiced "underground." However, in 1957 the National Association of Social Work acknowledged that private practice was in the "working definition of social work practice," and in 1964 private practice was officially recognized as "a legitimate area of social work practice in meeting human needs." It is difficult to know how many social workers are actually in private practice. In 1967 there was an estimate that 8 to 10 percent of social workers had a private practice; however, most of these had fulltime jobs, and only 5-10 percent of these had full-time private practices. In 1982 the number had grown to 12 percent in full-time practice with an additional 8 percent listing private practice as a secondary employment modality. Whatever the numbers, it is clear that the decrease in clinical job opportunities will greatly increase both the number of social workers interested in private practice and the number of patients that they see who are seeking such treatment. As the lucrative field of direct psychotherapeutic service is being accessed by clinical social workers, there are movements among certain groups of psychiatrists and psychologists to restrict

their direct reimbursement by third-party-payers. Such restrictive measures have been protested by many professionals, including psychiatrists and psychologists who believe that it is unfair to treat highly trained and qualified practitioners of clinical social work who possess skills that are important to public health as second-class citizens.

THE NURSE IN PSYCHOTHERAPY

Grounded in medicine, neurology, and psychiatry, tutored in the functional elements of psychology and dynamics, and with their appreciation of legal and personal responsibilities, nurses constitute an excellent resource in the mental health field. This fact was appreciated many years ago by Lemkau (1947, 1948) who pointed out that public health nurses played a most significant role in early emotional illness, since they saw people in their homes who were interacting with their families manifesting symptoms of emotional illness. The nurses easily established rapport with the family and were readily taken into the confidence of the various members. By careful listening they permitted emotionally distraught individuals to ventilate their feelings; they also reassured, imparted knowledge, and educated. Their contact with mothers at well-baby clinics and with prospective mothers at prenatal clinics enabled them to handle misconceptions, anxieties, and other potential founts of neurosis. Psychiatric nurses were also considered to be equipped to provide psychiatric therapy as a member of the therapeutic team (Committee on Function of Nursing, 1949; Muller, 1950; Committee on Psychiatric Nursing, 1952). In insulin shock therapy (Clawson & Peasley, 1949; Gayle & Neale, 1949), and brain surgery (Behnken & Merrill, 1949; Friedman, E. 1950), their role was regarded as being most constructive to the total treatment effort.

In 1950 Cameron indicated ways that nurses serving in a mental institution could act as psychotherapeutic adjuncts to psychiatrists. Indoctrination in psychiatry and psychotherapy, he avowed, enabled the nurse to assume some therapeutic responsibility. On the wards, for instance, the nurse could organize patients into a group and hold group discussions on a variety of impersonal and personal topics. These discussion groups, in goal and mode of operation, paralleled therapeutic groups. Cameron also described the possibility of employing the nurse in a psychotherapeutic unit of three, consisting of patient, nurse, and psychiatrist. Here the nurse functioned as a counselor, discussing and clarifying with the patient material that had been brought out by the psychiatrist. The nurse could also “role play” with

the patient, either acting out a role accorded the nurse by the patient, or gradually shifting this role, so that the patterns of behavior the therapist was seeking to change in the patient would be less and less satisfying to the patient.

Rennie and Woodward (1948) emphasized in an even more emphatic way that the nurse should be able to manage intelligently the more common psychiatric and emotional problems evidenced by the general medical patient. However, in expanding the nurse's role in therapy a reorientation was needed in concepts of the nurse's function. Required, furthermore, were better psychiatric educational opportunities for nurses. Bennett and Eaton (1951) also contended that basic instruction for nurses in psychotherapy was indicated inasmuch as all nurses who worked on psychiatric wards, whether this was acknowledged or not, did psychotherapy of one kind or another. Participation by the nurse in group psychotherapy was also endorsed by these authors.

With the expansion of the nurse's part in the mental health field revision of undergraduate nursing instruction was necessary—including more concentrated teaching of the dynamics of human behavior, of group relationships and the principles of counseling. Generally through the enlightened leadership of the American Nurses Association, educational programs have been encouraged that are designed for a diploma and qualification for license in practical nursing, for an associate degree and qualification for license as a registered professional nurse, and for a baccalaureate degree in nursing included courses to heighten the nurse's psychological role and function in the interest of the public's needs. Graduate and inservice programs were organized to prepare the nurse for more advanced practice.

The ANA Division of Psychiatric and Mental Health Nursing, over the past years, has attempted to define psychiatric nursing, to place it in proper perspective within the nursing profession and to project goals for nursing in psychiatric services (Conference Group on Psychiatric Nursing Practice, 1966). Qualifications for a psychiatric nurse at present are a Master's degree in psychiatric mental health nursing, license and registration as a professional nurse, and current engagement in direct or indirect psychiatric nursing care functions, as defined by the members of the ANA Division of Psychiatric and Mental Health Nursing and outlined in the 1973 Standards of Psychiatric and Mental Nursing-Practice. A revision of these standards in 1982 stressed the division of nursing practice into two levels; the first

involving brief counseling and problem solving which could be done by a "psychiatric nurse generalist" prepared at the pre-master's level and, second, clinical specialists in psychiatric practice who because of more intensive education on a master's or doctoral level could work more intensively with psychiatric patients in counseling and psychotherapy.

Gradually, the mental health role of the nurse has moved from the narrow confines of the hospital to the community at large. Whether associated with a psychiatric institution, a school, an industrial organization, a public health unit, a clinic, a camp, or a home, the nurse enters into intimate relationships with sick people and thus has unusual opportunities to practice principles of psychological helping. Such practice is determined by the needs of patients and their families and by the structure and policies of the agency under whose auspices the nurse works. While rendering a traditional service to patients with outright mental disorders in collaboration with other disciplines, the psychiatric nurse is also becoming more and more concerned with goals of promoting optimal mental health for individuals and their families in the community. In the concentrated contact with patients and their families the nurse has a unique opportunity to observe emotional interactions and relationships that may have a determining influence on the patient's illness and capacities for recovery and rehabilitation.

Recognition of the significance of emotional factors in both physical and mental illness has continued to foster psychiatric nursing as a most important part of the generic nursing curriculum. For a while there was an increasing number of nurses who pursued a preferred interest in mental health nursing (Sills, 1973) and pursued higher education to meet the challenge of a new role. In 1972 three universities offered doctoral programs in psychiatric nursing. In addition 42 programs offered Master's degrees (Liston, 1973). A new image of the nurse was evolving, one who could provide services to institutions and also direct patient care to clients within the context of family and the community (Rutledge, 1974).

This change in concepts of function has influenced our ideas about how best to provide psychiatric services for certain types of patients. Cumming (1972) stated: "Except for the prescription of drugs, there seems little in a number of modern descriptions of the psychiatric nursing role to distinguish this role from that of the psychiatrist." There are many who share this opinion to the effect that the group most intimately related with patients over a prolonged period, i.e., nurses, "should be the prime therapists

and bear the primary responsibility for treatment," the psychiatrist functioning in a consultative role. Truly the close contact that nurses have with patients under their care sustains a relationship with far greater therapeutic potentials than that afforded by the casual hours the psychiatrist can devote to treatment. As a primary therapist, the psychiatric nurse "assumes total nursing responsibility and accountability for the admission, nursing assessment, planning, therapy, evaluation, discharge and direction of a comprehensive plan of care for individuals diagnosed as psychiatrically ill, on a 24-hour basis" (Rutledge, 1974). The relationship with the psychiatrist is collaborative for medical aspects such as diagnosis and prescription of psychotropic drugs.

Recommended specialized areas of patient care include the nurse's participation in family therapy, behavior therapy, sociotherapy, group therapy, child psychotherapy, and individual psychotherapy. The employment of these techniques will depend upon the level of training, skills, and experience of the nurse, the requirements of specific psychiatric settings, and the availability of competent supervision. With proper training a nurse often makes an excellent family therapist. Since psychiatric nurses usually work with the family as a whole, they are in a strategic position to bring members together for discussions that serve to resolve intrafamilial hostilities. Nurses are also capable of doing expert behavior therapy with training. As a sociotherapist, the nurse contributes to community organization and functioning, working toward the solution of community mental health problems and the implementation of programs to their completion. Knowledge of how to organize a therapeutic environment, providing corrective and remedial experiences for patients, is basic to this function. Nurses often become skilled as sociotherapists and administrators of programs in milieu therapy, remotivation, and resocialization of groups in institutional settings. In group approaches the nurse may function either as a group leader or as a co-therapist. The group process, being more reeducative than reconstructive, will depend on group dynamics rather than on the analysis and working through of transference and resistance. Cooperating with other child therapists, a nurse may contribute to child psychotherapy, or with training, the nurse on a master's level may function as the primary child therapist.

In so far as individual psychotherapy is concerned, it is obvious that while bachelor's level psychiatric nurses can function as primary therapists with patients who require little more than a comforting counseling relationship, they will require as thorough graduate and postgraduate training as psychologists or psychiatric social workers do if they are to do more intensive psychotherapeutic work.

Patients, in their regressive needs stimulated by illness, often perceive the nurse as a symbolic parent. The nurse must be able to gauge the degree of active support that is realistically required, while encouraging independent operations in order to move the patient as rapidly as possible out of what may become a crippling dependency. Nurses must be cognizant of the dynamics of transference in order to control some of its effects. A knowledge of behavioral dynamics, an empathic and nonjudgmental attitude, and the ability to understand and manage personal countertransferential emotional reactions are important assets. At the same time the nurse must know how to provide a therapeutic milieu for the patient, manipulating environmental variables that require correction, assessing the social structure of the treatment unit, evaluating interpersonal relations among patients and staff, initiating and conducting remotivation and activity groups, and planning jointly with other professional workers the means of providing the best service for patients. These generic practices are aspects of the nursing function that can best be realized if the nurse has some self-understanding and is aware of personal motivations.

Functioning in an extended role as primary therapists, thus involves knowledge and experience for which many nurses are now being prepared and others can be prepared. A special committee, at the behest of the Secretary of Health, Education, and Welfare, (U.S. DHEW, 1971) was appointed to examine the field of nursing practice to offer suggestions on how its scope might be enlarged for the benefit of the public. A report published in the journal of the American Medical Association (JAMA 220:1231-1236, 1972) has accented the need for extending the range of services of the nursing profession, but has also stressed the need for further training that this extension would entail. The problem insofar as the psychiatric nurse specifically preparing for psychotherapeutic or psychoanalytic work is concerned is that opportunities for postgraduate education are still sparse since the nurse has not yet been accorded the acceptance deserved as a candidate for training on the same level as the psychologist and psychiatric social worker. One would hope that this disparity will be corrected in the near future.

Among the recommended readings are the contributions by American Nurses' Association (1973a, b), Crawford and Buchanan (1963), Burgess (1981), Critchey & Maurin (1985), Cumming (1972), Durham & Handin (1986) Ellen (1965), Freedman & Gordon (1973), Garrison (1973), Glover (1966), Haber, et al., (1982), Hofling & Leininger (1960), Johnson, BS (1986), Karnosh & Mereness (1962), Lego (1973, 1980, 1984), Liston (1973) Logsdon (1973) Manaser (1964), Matheney & Topalis (1965),

Mereness (1963, 1964), Norris (1963), Noyes, et al. (1964), Orlando (1961), Peterson (1969), Prowse (1957), Robinson (1964), Rutledge (1974), Schwartz, MS (1956), Sills (1973), Stuart & Sundeen (1983), Stueks (1965a & b), U.S. Department of Health, Education, and Welfare (1971), Wilson & Kneisl (1979), and Wolff (1964).

THE MEDICAL-NONMEDICAL CONTROVERSY

Medicine is traditionally defined as "(1) the science and art concerned with the cure, alleviation, and prevention of disease, and with the restoration and preservation of health… (2) the art of restoring and preserving health by means of remediable substances and the regulation of diet, habits, etc." *(Oxford Universal Dictionary,* 3rd ed.). Such a definition conceivably is broad enough to encompass psychotherapy. But whether it is practically justified in classifying verbal interchange, the communicative channel of psychotherapy, as an instrumentality of medicine has been open to challenge from non-medical professionals. For example, the question has legitimately been posed as to what we would call the activities of the minister who consoles a depressed parishioner, of the educator who handles a student's learning blocks, of the lawyer who directs a marital couple in conflict, of the guidance counselor who interrogates a school dropout, of the probation officer who works with a delinquent and the family, of the social worker who functions to rectify the neurotic uses by a client of social services, and of the public health nurse who persuades the neurotically uncooperative patient to attend to necessary health needs. Are they all practicing medicine?

In an attempt to resolve this dilemma some authorities have advised apportioning emotional ailments into medical and non-medical allotments. Such efforts are bound to end in failure because emotional problems influence every aspect of functioning—intellectual, emotional, and physiological—in an integrated way. As one observer put it,

> When a housewife becomes upset because her husband comes home intoxicated, can we say that she is manifesting a "medical" problem? If she is merely irritated "no," if she vomits or gets a headache "yes." But what if she shows an asymptomatic hypertension that predisposes to arteriosclerosis, or an altered gastric function that eventually may result in an ulcer? The fact that she is unaware of her physiological response, and that it is not diagnosed professionally, does not make her problem non-medical. Are interpersonal tensions associated with marital difficulties to be classified as medical problems? When a non-medical person works with an individual is he "helping" a "client," but when a medical person utilizes the same processes is he "treating" the same "patient"?

These differential points seem petty, but they are aspects around which much controversy brews. Another attempt to delimit the area of the non-medical worker is expressed in this way: "His field of specialization will be social, learning, and emotional problems within the 'normal' range of adjustment. His primary emphasis will be upon the development of optimal functioning rather than treating the emotionally ill" (Wright, MW, 1966). However, the definitions of "normal adjustment," "optimal functioning," and "emotionally ill" have never been clearly made.

The endeavor to bypass issues of operational definition has sponsored a disposition of the problem through classification of who is and who is not a psychotherapist. Lack of uniformity of sentiment was illustrated years ago by the following interchange from "California Dialogue: Defining Psychotherapy Insight" (Roche Report, 1965).

> *Dr. F. Janies Gay* (Neuropsychiatric Institute, Westwood, L.A.): Regarding the definition of psychotherapy, should its connotation be so broad that it includes non-medical people—such as social workers and psychologists? If so, aren't we jeopardizing the responsibility of our role in the medical profession? There are many instances where those outside of our specific medical field do not exercise the same clinical care for people they are working with as we do. I think the term, psychotherapy, perhaps ought to be restricted to working with feelings, fantasies, resistances, defenses as it is done by psychiatrists.
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> *Dr. Alexander S. Rogawski* (Past-President of the Southern California Psychoanalytic Society): I cannot agree. What is important is that a psychotherapist be a professional person educated for this task and that he belong to a self-policing and/or legally licensed group subscribing to a code of operational standards.

These two divergent viewpoints continue to be expressed by psychiatrists, the "oppositionists" maintaining that the medical model could never and should never be replaced by a social environmental model (Kaufman, 1967; Levine, A., 1971), some even insisting that "the end result of the egalitarian principle may be to debase psychiatrists and to promote paramedical team members to superior rank." *(Psychiatric News,* Aug. 2, 1972). The "progressives" on the other hand forsaw closer ties to non-medical professionals *(Psychiatric News,* Jan. 3, 1973). Some recognized the limitations of the medical model, and they foresaw non-medical people handling the bulk of treatment including psychoanalysis (Roche Report, 1974). Romano (1973) states, "I find it difficult to distinguish methods of psychotherapy as used by psychiatrists, psychologists, social workers, or nurses."

As far back as 1961 the Joint Commission on Mental Illness and Health (1961) pointed out the glaring deficiencies in the current care of mental patients, a situation that would, it was estimated,

become even more critical

> ...if the present population trend continues without a commensurate increase in the recruitment and training of mental health manpower. The only possibilities for changing this negative outlook for hundreds of thousands of mental hospital patients would require a great change in our social attitudes, and a consequent massive national effort in all areas of education, including large increases in the number of mental health personnel.

Among the recommendations were:

> (1) that the management of certain kinds of mental ailments be carried out by or under the direction of psychiatrists, neurologists, or other physicians specially trained for these procedures; (2) that non-medical mental health workers with proper training and experience be permitted to do general, short-term psychotherapy; (3) that psychoanalysis and "depth psychotherapy" must be practiced only by those with special training, experiences, and competence in handling these techniques without harm to the patient, namely, by physicians trained in psychoanalysis or intensive psychotherapy plus those psychologists or other professional persons who lack a medical education, but have an aptitude for, adequate training in, and demonstrable competence in such techniques of psychotherapy.

These recommendations obtrude themselves into the current smoldering conflict that, as has been indicated, involves two opposing forces. The first recognizes the great need that exists for therapeutic and preventive services that cannot possibly be handled by psychiatrists alone and sponsors programs for training other professionals in techniques of psychotherapy. The second force, activated by the filtering of non-medical people into the field of psychotherapy, seeks by legislation and public sentiment to subdue this trend. In the first group are psychologists, social workers, and other social scientists who resent the fact that psychiatrists have tended to preempt as their special province the entire field of mental health. In the second group are psychiatrists who view with alarm the invasion into the field of vast numbers of workers, particularly psychologists and clinical social workers who often independently offer treatment services to the public.

In the face of the tremendous demand that prevails for additional training, one may expect a continued expansion of non-medical postgraduate training facilities. This possibility has aroused great consternation in conservative medical circles. Alarm has especially been voiced at the development of psychotherapeutic training programs in universities. The arguments expressed are that the absence of proper screening of candidates, the concentration on didactic instruction, and the minimal amount of competent, intensive supervision threaten to turn out unqualified and inadequately trained individuals, not instilled, due to lack of experience, with the judicious caution and conservatism essential in

psychotherapeutic work. Such persons, say the oppositionists, constitute a potential public health menace of which they themselves are completely unaware.

Non-medical people reply by stating that it is essential to take a realistic view of the existing serious lack of psychiatric training facilities. This lack accounts largely for the alarming activities of untrained and unqualified therapists in the field of psychotherapy. These individuals not only mulct millions of dollars annually from the emotionally ill, but also inflict irreparable damage upon those who, having no other recourse, turn to charlatans and to relatively unskilled practitioners in an effort to alleviate suffering. Until sufficient numbers of skilled psychotherapists are available, we will always be plagued by the menace of charlatanry in the area of mental health. It is unrealistic to assume that the medical profession can ever supply from its ranks sufficient numbers of people to satisfy the ever expanding demand for mental health services.

More or less, the sentiment continues among the medical establishment, described almost 40 years ago by Szurek (1949) and Haun (1950), to the effect that the psychiatrist should transfer some functions to ancillary workers only within a supervised medical setting, and that the sharing of responsibilities dispels anxiety in the worker and facilitates better psychotherapy. This is contested on the medical side by a few who absolutely oppose any kind of psychotherapy by non-medical persons irrespective of supervision. It is contested also by the majority of non-medical therapists, who challenge the rights of 'he medical profession to impose on them obligatory controls, supervision, and other restrictions in the therapeutic work including private practice.

With the current scramble for the dwindling health dollar, opposition to independent non-medical psychotherapy has become even more strident. It is organized around one or more of the following arguments:

1. *Psychotherapy is an inherent part of medical practice.* Application of the methods of psychological medicine toward the understanding of the emotional states of patients aiding them to understand themselves *is* psychotherapy. Psychotherapy, hence, is a form of medical treatment and does not form the basis for a separate profession.

2. *A physician must bear medical responsibility for all psychotherapy.* While physicians may employ the services of other disciplines, the medical duties cannot be relinquished to a non-

physician. The physician remains responsible—legally and morally— for the diagnosis and treatment of the patient. In doing independent psychotherapy the non-medical person is assuming an unauthorized medical responsibility.

3. *All psychotherapy must be supervised by psychiatrists.* The medical profession endorses the appropriate utilization of the skills of other professions in medically supervised settings, such as hospitals and clinics, their professional contributions being coordinated under medical responsibility. This means that all psychotherapy must be supervised by psychiatrists. The non-medical person thus may function as an assistant to the psychiatrist in the diagnosis and treatment of patients. If in private practice, the non-medical person will require constant medical supervision.

4. *Only a medical background prepares the professional for an understanding of the human mind, in both its normal and pathologic reactions.* Emotional illness, being an organismic disturbance, requires a thorough grounding in the biologic sciences, which non-medical people do not receive.

5. *Only a medical background enables the professional to make a proper diagnosis.* A non-medical person is incapable of differentiating organic from psychologic disease. Because symptoms of emotional illness may mask organic and especially neurologic conditions, non-medical people may not recognize an early treatable condition until after it has become irremediable. Such instances have been reported in the literature (Kant, 1946; Eliasberg, 1951).

6. *Only medically trained psychiatrists have had sufficient experience with severe mental disorders to be able to deal with psychotic-like reactions and to differentiate these from milder disorders.* Only a psychiatrist has expertise and competency in psychopharmacology, shock treatments, and hospitalization procedures.

7. *The physician, by virtue of the unique position of prestige that he or she traditionally enjoys in the mind of the patient, operates in the most effective medium.* The non-medical person is handicapped in this respect.

8. *A strong sense of therapeutic responsibility for the patient is inculcated in the physician as part of medical training.* It is not so often possessed by the non-medical person.

9. *Society acknowledges that therapy belongs to the medical profession, and it sanctions the licensing of the latter.* In obtaining a license the medical therapist is subjected to a better screening process and measures of control than the non-medical person.

10. *Non-medical persons offer the medical profession unfair competition usually operating on the*

basis of lower fees.

Most non-medical therapists resent vehemently these attitudes and allegations of the medical oppositionists. To the arguments presented by psychiatrists, they make counterclaims that their own educational and experimental background equips them better to do psychotherapy than the physician. Having had access to the lush field of therapy, many non-medical practitioners resist continuing in a role of a technician or assistant. They insist that psychotherapy is not a form of medical practice, but rather it is an art in the management of interpersonal relationships. They contend that the orientation required by the medical sciences is totally unsuitable to the problems faced by the psychotherapist (Lindner, 1950). Emotional illness is not a disease that falls in the province of medicine. A medical education, therefore, in no way trains the individual to do psychotherapy better than other types of education.

To buttress their claims to psychotherapy, non-medical therapists point out that some of the most significant contributions to psychotherapy have been made by non-physicians—for instance, Anna Freud in the field of child psychoanalysis, Erik Erikson in "ego analysis," Erich Fromm in character analysis, Ernst Kris and Theodor Reik in formal psychoanalysis, Otto Rank in modified psychoanalytic therapy, S.R. Slavson in group therapy, and Carl Rogers in client centered therapy. They add to this list August Aichorn, Marie Bonaparte, Oskar Pfister, Bruno Bettleheim, Ernst Kris, David Rappaport, Alix and James Strachey, Joan Riviere, Ella Freeman Sharpe, Geza Roheim, Melanie Klein, and Hans Sachs from the field of psychoanalysis alone. Contributions of non-medical people to behavior therapy, cognitive therapy, group therapy, and other forms of psychotherapy are more than abundant. Indeed, some of the best psychotherapists are non-medical people. The latter are possessed of the highest integrity and function with a keen sense of responsibility for their patients.

It is obvious from these negative and positive claims and counterclaims, that opinion is sharply divided. There are responsible medical and non-medical authorities who are unalterably opposed to the practice of psychotherapy by non-medical persons under any condition. Others believe that such practice may be allowed in organized clinics or hospitals under circumstances of adequate psychiatric supervision. Still others do not object to the private practice of well-trained non-medical persons, provided that they operate in collaboration with physicians and psychiatrists. Finally, there are those who protest that psychotherapy has no identity with medical practice and that a trained non-medical

person knows when to bring a physician or psychiatrist into the picture if this is at all needed.

Representative of a prominent psychiatric viewpoint that is still extant is an article written by Norman Q. Brill (1957). Emphasizing the importance of trained clinical psychologists in understaffed state and veterans' hospitals, and admitting that they excel in certain areas of knowledge in the emotional factors of disease, Brill decries their influx into private practice where they assume independent responsibility for diagnosis and treatment and receive direct pay for their services. Brill blames the medical profession for not providing opportunities for supervision of trained clinical psychologists in private practice. Certification of psychologists, he continues, is a well recognized need to protect the public from inadequate and unqualified practitioners. "Any law to certify psychologists should also define psychotherapy and prohibit the treatment of mental or emotional diseases by a psychologist except under the supervision of a physician. If such a provision is omitted, an independent profession which competes with the medical profession is likely to result." Brill sums up quite adequately the opinion of a large segment of the medical profession. His conclusions are worthy of further exploration.

The first point relates to psychotherapy as a process. Definitions of psychotherapy are so diffuse, even in terms of its processes and goals, that there is little chance that lawmakers can do that which the psychiatric profession has been unable to do, namely, to arrive at a designation satisfactory to the majority of concerned parties. The classical example of how difficult this can be was the failure of a committee appointed by the American Psychoanalytic Association to agree to a definition of only one aspect of psychotherapy, namely, psychoanalysis.

Prohibitions as to the treatment of mental or emotional diseases by a non-medical person would call for adequate policing. Who would determine when the latter has overstepped the bounds? What distinguishes "treatment" from "conversing with," "guiding," "advising," and "counseling"? Obviously, one cannot prevent an individual from talking to another individual and, if agreeable to both, charging a fee for the service. Would it be the subject matter of the communications? The kinds of verbal and nonverbal responses of the therapist? The discussion by the client of dreams, transference, and resistance? Insuperable problems invest attempts to delimit the nature of the communicative flow between any two people.

The matter of identifying a mental and emotional problem and distinguishing it from an "ordinary" problem also needs to be considered. An individual seeking spiritual guidance from a minister may be suffering from a serious mental and emotional disorder, as may a person with a work problem who consults a vocational counselor, or a student failing at school who insists on talking to an educational psychologist. Essential in dealing with the manifest complaint may be the listening to more underlying intrapsychic conflicts. Should the non-psychiatric profession divert the client from talking about these? Would not this professional be shirking helping responsibilities within his or her own field? Apart from the fact that our diagnostic classifications are amorphous and unsatisfactory, we cannot truly distinguish in many instances the pathological from the "normal" since definitions embrace social sanctions and cultural factors that have little to do with health and disease.

The matter of compulsory supervision by a physician brings up some confounding contradictions. How can this be practically arranged? What happens when the non-medical person is (1) the only person trained to do psychotherapy in a certain area and (2) more sophisticated in therapeutic techniques than the physician who is assigned as supervisor? Trained and skilled non-medical therapists now function as psychotherapeutic supervisors to physicians in clinics and hospitals. Should such training therapists, in turn, be supervised by physicians, and, if so, for what purpose? Should compulsory supervision by the medical profession apply only to those in the private practice of psychotherapy and not necessarily to those in clinics, hospitals, or other medical settings? Where can one expect to find the additional psychiatrists who would be needed to supervise the large numbers of non-medical practitioners?

The last point—regarding the competition between non-medical people and psychiatrists—is perhaps the most crucial issue. Competition (and consequently conflict) exists in the area of mental health as it does in any other field where human beings vie with each other for recognition, status, power, and economic security. Non-medical therapists would seem to pose some economic threat to psychiatrists if it were true that there were limited opportunities for practice. While this may hold for patients who can afford to pay high fees in a few zones within large urban communities, it does not apply to the country as a whole. There is a gross shortage of trained personnel in the mental health field, including those who restrict themselves to the treatment of emotional illness. There is especially a dearth of psychiatrists, clinical psychologists, psychiatric social workers, and psychiatric nurses.

To all of these propositions non-medical professionals have their own answers. Among these is the allegation that psychotherapy is a form of medical practice only where it includes the giving of drugs and the use of the convulsive therapies and psychosurgery. Verbal interchange, the vehicle for psychotherapy, cannot conceivably be graded as a medical procedure. It is manifestly preposterous to insist on medical supervision for all non-medical workers under such circumstances. Even though this could be arranged, it would be quite impossible to administer adequate policing procedures.

Some psychiatrists counter with the statement that while guiding, counseling, reassuring, and supportive tactics are legitimate aspects of the non-medical disciplines, and therefore lie outside the responsibility of the physician, dealing with the intrapsychic processes and employing any kind of probing technique are medically corrective operations. Among the most insistent champions of this viewpoint are the psychoanalysts.

Even here there is no complete agreement, some leaders in the field being not at all convinced that psychoanalysis is a medical procedure. Years ago Freud, himself, defending charges made against Theodore Reik, the noted psychologist, said:

> I have assumed, that is to say, that psychoanalysis is not a specialized branch of medicine. I cannot see how it is possible to dispute this. Psychoanalysis falls under the head of psychology; not of medical psychology in the old sense, or of the psychology of morbid processes, but simply of psychology. It is certainly not the whole of psychology, but its substructure and perhaps its entire foundation. The possibility of its application to medical purposes must not lead us astray. Electricity and radiology also have their medical application, but the science to which they belong is none the less physics. (Collected Papers, Vol. 5, p. 207)

Freud also wrote:

"I lay stress on the demand that no one should practice analysis who has not acquired the right to do so by a particular training. Whether such a person is a doctor or not seems to me immaterial" *(Standard Edition,* Vol. 20, p. 183). "The practice of psychoanalysis calls much less for medical training than for psychological instruction and a free human outlook" (Introduction to Pfister's *The Psycho-Analytic Method.* Standard Edition, Vol. 12, p. 329).

Maxwell Gitelson (1964), a past president of the International Psychoanalytic Association, questioned almost 25 years ago whether psychoanalysis should loosen its adhesion to medicine:

> The prevailing tendency to place exclusive value on antecedent psychiatric training as such may need to be revised in respect to the barrier it erects against scientists with other qualifications who might advance the conceptual horizon of psychoanalysis. While there may have been valid reasons in the late thirties for American psychoanalysis to declare its exclusive adhesion to medicine as its parent discipline, the question must be raised whether these reasons retain their cogency today... .

A Position Statement of the Preparatory Commission on the "Ideal Institute" for the National Conference on Psychoanalytic Education and Research reiterated many of these ideas (American Psychoanalytic Association, 1974).

On the other hand, a large body of psychoanalysts, Freudian and neo-Freudian, protest that Freud was wrong when he identified psychoanalysis as a psychological rather than medical discipline. This is less the case in their personal relationship with lay analysts, and when voicing their private opinions to a select group of intimate friends, than when they are gathered together in a medical body where their sentiments may be recorded.

Some attempts have been made to classify psychotherapy by including it in the phrasing of certification laws. There is a considerable variation of such laws among the different states. As a rule, certification qualifies a professional to use the title of "certified psychologist" or "psychologist" or "social worker." Some laws include a definition of the practice of psychology or social work; others do not. In the former case certification becomes practically equivalent to licensure. Generally, the certification law excludes the right to engage in the practice of medicine as defined in the laws of the state. In some cases the law includes "psychotherapy" or a form of "clinical counseling" as one of the functions of the psychologist or social worker.

A few medical organizations and groups oppose the concept of certification on the basis that they are against *any* legal recognition of psychologists or non-medical people. In the main, however, there is approval of the concept of certification if it confines itself to the simple protection of a title. In some instances, however, it goes considerably beyond this.

SUPERVISION OR COLLABORATION?

The basic positions of the American Medical Association and the American Psychiatric Association were expressed in 1964 as follows:

> To place the most critical aspect of the problem under specific discussion in its proper perspective, namely the professional need for cooperatively defining and respecting the areas of activity and responsibility for scientists who participate in the care of the patient, it must be fully realized that physicians have the ultimate responsibility for patient care, and that they, and they alone, are trained to assume this responsibility. In the public interest, other scientists, when contributing to this patient care, must recognize and respect this ultimate responsibility. Moreover, not only must there be mutual respect for different abilities and special qualifications, but also concomitant recognition of the interdependence of scientists and physicians in promoting health... .

The viewpoint of the American Psychological Association in 1962 (code of Ethical Standards for Psychologists) was:

> The profession of psychology approves the practice of psychotherapy by psychologists only if it meets conditions of genuine collaboration with physicians most qualified to deal with the borderline problems which arise [e.g.] differential diagnosis, intercurrent disease, psychosomatic problems... . The psychologist recognizes the boundaries of his competence and the limitations of his techniques and does not offer services or use techniques that fail to meet professional standards established in particular fields. The psychologist who engages in practice assists his client in obtaining professional help for all important aspects of his problem that fall outside the boundaries of his own competence. This principle requires, for example, that provision be made for diagnosis and treatment of relevant medical problems and for referral to or consultation with other specialists.

The Council of the American Psychiatric Association (1963), reviewing the general views expressed above, concluded:

> It must be considered axiomatic that the purposes of "genuine collaboration" is to benefit patients and that it can take place only when there is mutual trust and respect between two professional groups... . The essential problem is how to assure the patient of medical control over his medical care, regardless of the professional background of the psychotherapist. Complete medical control, rigidly interpreted, implies supervision of the psychologist by the psychiatrist. As indicated above, however, in actual practice, the relative rigidity of interpretations of "medical control" will vary according to several factors. For example, the patterns of practice in a university hospital differ from those of a state hospital, and these in turn differ markedly from practice in an urban or suburban upper middle class milieu. From these must be differentiated the small city or rural area where few, and often no, psychiatrists are to be found.
>
> Mere referral of a patient to a psychologist for psychotherapy or testing, without follow-up contact or consultation between psychiatrist and psychologist cannot be considered "genuine collaboration," although it is recognized that in certain cases and circumstances the initiative for further follow-up consultation is properly that of the psychologist. When organic pathology— peptic ulcer, for example—is present, the appropriate consultant for the psychologist, and often the psychiatrist, is the internist, family physician, or other medical specialist. The sustaining principle is that close and frequent contact between the psychiatrist and psychologist is essential, and most especially in borderline cases where there may be a risk of suicide, for example.
>
> While supervision at regular intervals, weekly, for example, might be advisable in some cases, the reality must be faced that it is impracticable in the majority of cases, even when the psychiatrist and psychologist desire it. The manpower and the man-hours are simply not available. Some psychiatrists insist on this as essential to their collaboration, as is their right. It is the Committee's opinion, however, that the rule cannot be universally

> applied since to do so would make it impossible for psychiatrists generally to meet all of the requests for supervision in all cases together with their other obligations.

It is apparent from these statements that the relationship of medical persons to psychologists is being regarded as more collaborative than supervisory. The concluding paragraph of the report contains this item:

> Thus, the overwhelming public interest leaves no place for petty squabbles in building more effective interprofessional relations between the two major professions dedicated to the better understanding of human motivation and behavior. What is called for is a sustained, thoughtful seeking of answers to the fundamental questions posed herein—answers which will be in the best interests of the mentally ill. The American Psychiatric Association proposes to work to this end and urges upon its District Branches that they lend support in every feasible way to improving the liaison between psychiatrists and psychologists at the state and local level.

In 1974 John P. Spiegel, President of the American Psychiatric Association, wrote that it was possible for certain mental and emotional disorders to be "treated effectively by mental health professionals other than psychiatrists. Some disorders usually require the special skills of the psychiatrist in both diagnosis and treatment. Still others can be in most circumstances appropriately treated only through a collaborative effort of psychiatrists with other professionals."

Opposed to the idea of collaboration rather than supervision, however, are some dedicated groups of psychiatrists and physicians who support what Levine wrote in 1965:

> We hold that the treatment of the emotionally disturbed and mentally ill patient is a medical responsibility and as such cannot be assumed by any other than a medically trained therapist… .

Invasion of medical practice, it is claimed, cannot be countenanced. Ultimate responsibility must not be assumed by the psychologists since they are not trained to diagnose organic disease and to prescribe for them which activities are fundamental to treating the emotionally and mentally ill.

To this, other psychiatrists disagree for reasons similar to those expressed by Edward Gardner (1965), Chairman of the Editorial Board of the *Newsletter of the Psychiatric Society of Westchester:*

> The issues with which we are urged to concern ourselves are "lay therapy," "unsupervised lay psychotherapy," "licensure" and "relations with allied professions." The small print in the Bulletin articles reads with somewhat more heat than objectivity. We find there references to spreaders of "cancer," "nefarious" practitioners, "flagrant offenders" and even "an assault on the practice of the psychiatry." Hardly the language of a scientific dialogue!

> One article raises the question of "ultimate responsibility for the welfare of the patient." This is a thorny problem filled with seductive primrose paths. Basically, the question of "ultimate responsibility" rests with the individual himself. We rightfully delegate responsibility to appropriate experts in a variety of fields from carbuncles to carburetors. This follows the enormous complexity of our lives and increasing wealth and welter of specialized technological data. However, I feel it is more than presumptious for any single discipline to claim the right to assume "ultimate responsibility" for such an ill-defined segment of the human experience as the one with which we are all struggling. Let us not forget that as physicians we have had certain responsibilities *delegated* to us by society. This does not mean, however, that in any sense we enjoy a variety of divine right.
>
> The time may well have come for cooperative efforts directed toward the welfare of the public. These rather than moves which antagonize and elicit defensive and alienating behavior. Several outcomes are within the realm of possibility: (1) that "unsupervised" psychotherapy becomes the private property of the medical profession to the exclusion of all other disciplines; (2) that ultimately (Perlsh the thought and our humanity along with it) psychotherapy atrophies from disuse in the face of a greatly expanded and refined psychopharmacology; (3) that psychotherapy becomes a separate and collaborative discipline with its own standards of competence and proficiency based on principles sounder than those that currently support it.
>
> The futility of evolving a law, or of enforcing it, that permits "counseling" by non-medical people (caseworkers, psychologists, nurses, ministers, lawyers, etc.) and forbids "psychotherapy" except under medical supervision is accented by the fact that a sharp distinction between counseling and psychotherapy cannot be drawn. *There is no law that can possibly prevent people from doing psychotherapy under the name of guidance or counseling.*

According to the General Counsel of the American Medical Association (J.A.M.A. 247:3-360, 1982) it is not legally required for a non-medical professional in independent practice to call for an examination by a physician before or during treatment of serious behavioral or psychological disorders. Existing licensure laws recognize an independent role for designated non-medical professionals. "Anti-trust laws provide protection against artificial barriers and obstacles that interfere with the legitimate practice of a profession." Citing such a law on March 1, 1985 the group for the Advancement of Psychotherapy and Psychoanalysis in Psychology sponsored the filing of a class action, anti-trust lawsuit against the medically constituted American Psychoanalytic Association as hindering the attempts of American psychologists "to study, teach, and practice psychoanalysis both in this country and abroad." The lawsuit supports the idea that "psychologists of all theoretical persuasions should be free to teach, train, and practice without medical dominance or exclusion." This action had the endorsement of the American Psychological Association. Moreover psychologists, to the consternation of the medical profession, are aggressively defending their right to unqualified reimbursement for services and are threatening legal suit for restraint of trade. New standards of the Joint Commission for the Accreditation of Hospitals allow individual hospitals to decide what licensed individuals other than physicians may be given clinical privileges subject to what applicable state laws or licensure requirements may stipulate, and in conformity with the policies and bylaws of the medical staff. In this way non-medical professionals,

gaining membership to the Medical Staff of Hospitals can admit and treat their own patients. Needless to say, psychiatrists consider this a threat to their own practices. More and more states are defining a role for psychologists in the civil commitment process. In Virginia, psychologists won a battle with Blue Shield over their refusal to pay psychologists unless services were billed through a physician. The ruling in favor of psychologists was upheld by the U.S. Supreme Court. The appeals courts said "we are not inclined to condone anticompetitive conduct upon an incantation of 'good medical practice.'"

As clinical social workers have become more involved in the practice of psychotherapy they too have been demanding rights to reimbursement by third-party-payers for the treatment of patients in private practice. In some states they have been successful, securing licensure and reimbursement privileges in spite of the activity of The American Psychiatric Association, which has launched a campaign against such privileges on the basis that a comprehensive psychiatric assessment is needed prior to initiating therapy, which is crucial for proper diagnosis and treatment planning.

TOWARD AN ECUMENICAL SPIRIT IN THE MENTAL HEALTH FIELD

Continuing shortages of psychiatrists and the growth of community mental health centers have necessitated staffing the centers with trained non-medical personnel who more and more are working on a par with physicians. Recognition that the medical model is not applicable to all emotional and behavioral problems has resulted in the recruiting of teachers and supervisors from non-medical areas. There are ample evidences of new winds that are blowing to accelerate the acceptance by the psychiatric profession of their colleagues in clinical psychology, psychiatric social work, and psychiatric nursing. We may, however, expect that the fraternal spirit is not consistent nor universal and that the next day may see vitiated what today sounds like a new dawn of tolerance and reconciliation.

We have seen only too vividly how the untidy squabbling among competitive disciplines rises and falls with the economic tides. Indeed, as governmental budgeteers have slashed away at allocations for research, training, and treatment, forecasts of a belt tightening and cadaverous era for mental health funding are supporting a struggle for territorial rights. As national health insurance edges into the picture, the prestigious American Psychiatric Association (1974) issued a *Discussion Guide on National Health Insurance* "for discussion purposes only," acknowledging the need for allied non-medical services,

but suggesting that reimbursement presuppose non-medical professionals operating as part of a treatment plan prescribed and supervised by a physician. This statement has been considered by some psychiatrists and most non-medical people as constituting a backward step in relations among mental health professionals. Reimbursement, they insist, should be on the basis of training, functional role, and competence—irrespective of discipline.

The need for greater cooperation among the mental health professions is generally acknowledged. Howard Rome (1966), past president of the American Psychiatric Association, in his address at the opening of the Association's 122nd annual meeting, called for a new coalition of all the social sciences in which no one discipline would be supreme. He urged that psychiatrists abandon the "invidious" conviction that they alone can understand the vagaries of human behavior. In a similar vein the Committee on Psychopathology of the Group for the Advancement of Psychiatry has emphasized the need for collaborative research in the field of mental health and has pointed out that interdisciplinary working together on any single project results in more adequate checks upon interpretations and hypotheses and also more fruitful conclusions. The highest degree of collaboration is possible where the disciplines are able to communicate with each other. This requires education in allied fields of interest. However, interdisciplinary rivalries and hostilities and the bans levied by some psychiatric groups on the training of non-medical personnel in psychotherapeutic techniques militate against this objective.

A good deal of the misunderstanding between the professions of psychiatry and psychology is due, as Dickel (1966) pointed out, to the fact that "the two groups have never really understood the difference between the medically-oriented and the psychologically-trained doctorate. ..." Recognizing that each discipline is geared toward "the good mental health of each citizen, [they] should be able to comfortably cooperate, and yet should not at any time encroach upon each other's legal, professional, and moral responsibilities, duties, or functions." In his article Dickel describes clinical psychologists as a highly screened, selected, trained, and skilled group of professionals, with many years of academic schooling, who believe themselves capable of policing their own functions. Independently "they have developed intraprofessional, voluntary means to maintain and advance professional competence; they have initiated qualifying boards for recognition of this competence by their peers, and they have established their own scientific societies with suitable credentials for membership." With disciplined postgraduate education, he continues, clinical psychologists are capable of studying and working with

the psychologic state of an emotionally disturbed person. Whereas medicine and medical education gear the physician toward an organic view of the human being and support the implication that behavior is not a medical responsibility, psychology and psychological education are largely in the psychosociological-cultural field, concerning themselves with certain aspects of behavior as their principal province.

Certain attempts have been made by some to reconcile the training differences of psychologists and physicians. Thus L. S. Kubie (1947), acknowledging the shortage of existing clinical services and of training facilities for psychiatrists and commenting on the fact that it requires from 10 to 12 years to train one to be a mature psychiatrist and psychotherapist, advocated the setting up of a paramedical discipline of medical psychology with a condensed, concentrated training program of 5-6 years to be conducted in medical schools and teaching hospitals. Among the courses included would be basic training in anatomy, clinical physiology, and clinical pathology of the normal and abnormal organic processes. Certain aspects of medical education would be omitted, such as most gross and microscopic pathology, clinical pathology, laboratory techniques, and bacteriology. Clinical clerkship would involve history taking, nursing care of patients, and administration of psychologic test batteries. Personal psychoanalysis could begin at any time after work on organic wards is started. Such a program would lead first to an understanding of how organic factors and ailments influence the person psychologically; second, to a special sense of responsibility toward the patient as a sick individual; third, to an objectivity in one's clinical evaluations; and fourth, to self-criticism. With two or three years of supervised psychotherapy, candidates should become fairly seasoned therapists.

J. G. Miller (1947) also foresaw a future blending of medical and psychologic curricula in an extensive kind of training. Undergraduate instruction leading to a Bachelor's degree would consist of 2 years of liberal arts college, 1 year of advanced clinical psychology, sociology, and cultural anthropology, and 1 year of preclinical medical subjects comparable to the first year of medical school. After this, the candidate would enter the second and third years of medical school, and then do medical and psychiatric clinical work for 1 year at a general hospital, mental hygiene clinic, or neuropsychiatric hospital. The granting of an M.D. degree in the psychologic sciences would be followed by 1 year of a rotating psychologic-psychiatric internship, which would include experience in psychologic diagnostic methods and the performance of different psychiatric duties. After this, there would be 1 year of

independent research leading to a dissertation. Seminars and a personal psychoanalysis would also be included. Successful completion of these requirements would result in an award of a Ph.D. in clinical psychology. From this time on the candidate would work for boards in psychiatry, clinical psychology, or both.

G. E. Gardner (1952) stressed the need for contact with seriously ill mental patients as part of the training program for psychologists, and he indicated that unless there is a prolonged exposure to the problems of such sick patients, the candidate is handicapped in developing a proper "clinical attitude." For this reason, at least 1 year of work in a state hospital in close contact with mental patients was recommended as a minimum for all non-medical therapists, including psychologists.

At present similar formulas are propounded with some modifications. Upsetting the professional caste system is the proposition that all psychotherapists, irrespective of discipline, are alike. Supporting this contention are the surveys reported by Henry et al. (1971) who discuss the advisability of setting up a psychotherapeutic "fifth profession." Holt (1971) has included in his book the opinions of leaders in clinical psychology, psychoanalysis, psychiatry, and social work regarding what is necessary for the development of the new profession of "psychotherapist." Criteria for training and accreditation, arguments for establishing a new type of professional school, and the essential curriculum are topics that lead to conflicting views and controversial and unconventional conclusions.

There is generally a feeling that any planning for future educational programs must take cognisance of the fact that ideally what will be required is exposure to a broad range of techniques that include psychoanalysis, behavior therapy, cognitive therapy, hypnosis, strategic therapy, milieu therapy, group therapy, family therapy, couples therapy, and pharmacotherapy. Training should embody when and how to implement these techniques, and their effective integration toward the most extensive objective of personality reconstruction where the patient is able to benefit from this. There are some who forsee education that would lead to a special degree (Doctor of Mental Health) and would encompass all the courses in medicine, psychology, social work, and education that have pertinence to mental health (Watson 1970, Holt 1971, MacDonald 1978). The program described by MacDonald (1978) which is cosponsored by the University of California at Berkeley, Mount Zion Hospital, and Langley-Porter Neuropsychiatric Institute sounds promising. Another design is that after obtaining a bachelor degree a

candidate would enter medical school for two years of selected medical courses, eliminating courses that are not essential to psychiatric practice. The next two years would be spent in schools of psychology and social work getting instruction in counseling, psychological testing, mental health research, community mental health and other related areas. There would be assignments to social and other agencies for practice and experience. During this period or even before candidates could start their personal psychoanalysis and analytic training. They would also participate as patients in a therapeutic group. The last two years would be as residents in a mental institution, at the same time acquiring experience in multimodal therapy and differential therapeutics, learning all the important techniques essential for work as mental health specialists. They would be required to engage in an extensive research project as well as a community project where they would learn community mental health consultation. Finally they would get courses in supervision of psychotherapy. With this comprehensive kind of grooming they would be licensed to practice as a Mental Health Specialist able to do various kinds of treatment, write prescriptions for medication, admit and treat patients in hospitals and do all or more than psychiatrists, psychologists, and social workers are trained to do today in the mental health field.

We may expect a number of roadblocks that inhibit this kind of education. The most likely hindrance will be the power structures of the professions which, having a vested interest in maintaining their identities, are unable to tolerate change. Another impediment is that unfortunately technological advances have progressed much faster than man's capacity to adapt to them. We see examples of this not only in the area of mental health but in many divisions of the biological and social sciences.

It is doubtful that there is any professional who does not recognize differences in the training and function of physicians and non-medical professionals. There are areas where the psychiatrist is at an advantage due to an educational and experiential background. Biochemical, neurophysiological, and physical dimensions of an emotional problem are more easily recognized and treated by a physician. Years spent in residency in a mental institution sharpens diagnostic and therapeutic skills especially in relation to the more serious mental disorders like schizophrenia, borderline conditions, mania, depression, psychosomatic ailments, and organic brain disorders. The prescription of psychotropic drugs is a function assigned for the most part to physicians since it calls for an understanding of their therapeutic influence and handling of untoward side effects. Specially trained psychiatrists can administer ECT and narcosynthesis when needed. If psychiatrists have not drifted away too much from

medicine, they know how to recognize physical conditions that display themselves as psychiatric problems and vice versa. Psychiatrists have the ability to function in liaison consultation with other physicians in general hospitals or private practice. They have experience in dealing with psychiatric emergencies that present themselves at the office, outpatient clinics, emergency rooms, crisis units, and community mental health centers.

The areas in which psychiatrists are at disadvantage because of education relate to psychological and social factors that may confront them in the workplace. Cooperation with psychologists and social workers may serve an educational function toward understanding the crucial part problems of living play in mental illness. But since psychiatrists have been trained to consider themselves as ultimately responsible for the total treatment of patients across the entire biopsychosocial spectrum, construction, and supervision of a treatment plan by non-medical workers in an agency or community mental health center may create conflict within. Psychiatrists usually do accept the fact that psychiologists may in their schooling have had more training in counseling and perhaps in behavior therapy, and are better equipped to work with patients who require counseling or who need a behavioral approach for certain conditions like phobias, obsessive compulsive symptoms, and habit disorders.

It is only at the point where some kind of psychotherapeutic technique is employed that difficulties in defining roles arise. Each group feels entitled to the right to use psychotherapeutic procedures by virtue of its historical development, but each group must also take the responsibility for delineating what it is that their members are equipped to do by training and experience. Those who have had adequate training to do psychotherapy may help persons with emotional problems with reasonable certainty of success. Those who are not so trained should not be entitled to represent themselves as psychotherapists, whether they be psychiatrists, clinical psychologists, psychiatric social workers, or psychiatric nurses. At the moment there is no new profession of psychotherapy. Questions of licensing and standards automatically raise many issues. Organized social work, nursing, psychology, and organized medicine are actively participating in trying to define their roles in private and agency practice, including psychotherapeutic operations.

While there is no uniformity of sentiment, some general propositions may be tendered. The following are some suggested guidelines:

1. *Competence in the conduct of psychotherapy has little to do with the kind of degree that the psychotherapist possesses.* Professionals with an adequate background in psychiatry, clinical psychology, psychiatric social work, or psychiatric nursing with proper training, supervision, and perhaps personal psychoanalysis, may learn to do good psychotherapy. The need for adequate postgraduate specialized training for all professions, however, cannot be overemphasized.

2. *Morality is not a medical monopoly.* An ethical non-medical therapist has just as much concern and feelings of responsibility for a patient as does an ethical physician. There are, of course, exceptions. However, a few non-ethical practitioners in both medical and non-medical categories do not warrant generalizations that extend to the entire profession.

3. *Training in an interdisciplinary setting is the preferred locus in enriching the understanding of all of the related professionals.* It results in mutual respect for the contributions that the respective professions have to make in the total treatment and preventive programs. It enables the non-medical worker to recognize the need for a relationship with the psychiatrist, and it equips him or her to work collaboratively with the psychiatrist. It apprises the psychiatrist of the special services other workers have to offer in a collaborative work setting with them. Training in an interdisciplinary setting tends to make medical and non-medical trainees highly aware of their community responsibilities; after their training has been completed, they are more prone to devote some of their time to community work.

4. *All patients should coordinately be under the care of a general medical practitioner who diagnoses, treats, and when necessary, refers the patient to other medical specialists for further study of physical ailments.* Because psychologic disorders may be a reflection of underlying medical and neurologic problems, all patients entering any kind of a treatment program should be thoroughly checked by an internist to ascertain the presence of physical illness and neurologic disease. In the course of therapy a periodic medical checkup is essential. In practice, nearly all patients who seek help from psychotherapists have their own family physicians. Any patient who is in therapy with a psychiatrist, should also be coordinately under the care of a family physician or be referred to one for an initial diagnostic examination and periodic checkups, since the psychiatrist will probably not be managing the physical problems. In view of the increasing lawsuits against psychotherapists for not employing proper medical safeguards in treatment, we may expect greater collaboration and consultations of non-medical therapists with physicians and psychiatrists.

5. *There are certain patients who should preferably be under the care of a psychiatrist* whose background best equips him or her to administer somatic therapy and to handle

emergencies that may arise. Included are severely depressed and suicidal patients; violently excited, disturbed, and dangerously assaultive persons; decompensated schizophrenics; acting-out alcoholics and drug addicts; patients whose difficulty is prominently or exclusively expressed in somatic pathology (somatoform disorders); and individuals who require electroconvulsive and constant psychotropic drug administration. Where the non-medical professional is obliged to carry on psychotherapy with such patients, he or she should work collaborately with a psychiatrist who will be available for consultation at all times and who may step in to manage psychiatric emergencies should they precipitate.

6. Assuming that safeguards are maintained in regard to the medical status of the patient, *professionals trained to do psychotherapy and who have had sufficient supervised clinical experience may be able to do psychotherapy under such supervision of the psychotherapeutic process as their level of training demands, by a medical or non-medical supervisor.*

It will be apparent from the diverse arguments and opinions that have been presented that no easy solution of the suspicions and hostilities between medical and non-medical professionals is in sight. The bitterness that has developed between them has not been in the public interest. Charges and countercharges bring discredit to both professions. The controversies have done little other than to isolate the two groups from one another. In some cases actions have been instituted to extend the medical practices acts to include psychotherapy in order to bar "unqualified and unsupervised persons" from doing psychotherapy. Since improper practice is the product of lack of enforcement of existing medical practice acts, amendment of the present acts are, however, generally not believed to be necessary. Lawsuits solve very little, for basic disagreements between medical and non-medical opponents cannot be settled by legislation or contests for public support. If psychotherapy is ever to develop into a scientific discipline and if we are ever to bring therapeutic facilities within the bounds of community needs, it is mandatory that a solution be found to the differences that exist between physicians and non-physicians in the field of mental health. Reciprocal respect and tolerance are essential before we can even begin to approach the problem constructively.

OTHER HELPERS IN THE MENTAL HEALTH FIELD

As has been previously indicated, a number of workers other than physicians, nurses, clinical psychologists, and psychiatric social workers come into contact with emotionally disturbed persons. Chief

among these are non-psychiatric physicians, ministers, teachers, police officers, and mental health aids or "paraprofessionals." Where they possess the proper training and skill, such individuals are in a strategic position to detect incipient neuroses or psychoses, to educate clients in the principles of mental health and the meaning of emotional disturbance, and to refer those in need of psychotherapeutic services to available resources. The kind of therapeutic help that these workers are capable of rendering is generally of a supportive nature contingent on the warm relationship that is established, the opportunities for verbalization and emotional catharsis that are offered, and the employment of casual measures of reassurance and persuasion. In a few instances a gifted helper who has received sufficient postgraduate training may be able to do reeducative therapy. This individual may thus be capable of influencing personality forces at a time when the neurosis is relatively reversible and before obdurate accretions of neurotic defense have accumulated.

The entry of helping persons of varied disciplines into the mental health field is, nevertheless, not without its dangers, for there are always aggressive enthusiasts who do not recognize or accept their limitations of function. Insisting that they are not "helpers" or "counselors" but "psychotherapists," they may plunge recklessly into situations beyond their understanding, in this way potentially harming the patient as well as endangering their own professional stature. This, however, should not discourage the organization of proper educational training programs. Experience demonstrates that with additional education helping persons become more adept, and also more conservative, in what they can do psychologically for their clients.

It is unrealistic to assume that trained psychotherapists can ever supply from their ranks sufficient practitioners to satisfy the ever expanding demands for mental health services. If our concern is with the needs of community, it will be necessary to employ counselors and helpers on whatever levels they may best serve.

Proper training is of utmost importance for new roles in providing service. Well-organized didactic courses combined with small-group discussions and personal group work or personal psychotherapy are helpful in facilitating the most effective execution of duties. Personal psychotherapy provides a discernment of psychodynamic factors that cannot readily be grasped through the traditional didactic courses and case conferences.

The Non-psychiatric Physician in Mental Health

Whether desiring it or not, family physicians are often put into a position where they must function like psychotherapists. A woman with a blinding headache spills out her concerns about her adolescent son whose misbehavior is "driving her insane." A man recovering from a heart attack expresses his anxiety about his future: the support of his family, resumption of sexual relations, the possibility of a cardiac relapse. A teenage girl is insistent upon receiving contraceptive advice and confides that she is having an affair with a married middle-aged man. Liver involvement in a young alcoholic, an intractable gastric ulcer in a tense spinster, insomnia that resists hypnotics, persistent vomiting without cause, suicidal threats in depression, refusal to give up smoking in emphysema, dieting failures in obesity, and a host of other challenges are examples of what may confront physicians in their daily practice and force them to assume a psychological stance for which they may be little prepared. Actually, the doctor may be the only person a patient will consult for the myriad problems that beset human beings during various age periods. Not only must physicians know what is normal at the different age levels, but they must be able convincingly to communicate facts to the concerned parties and deal with resistances to their absorbing these facts. They must know how to manage the emotional reactions of patients with chronic disabling diseases and terminal illness as well of individuals about to undergo surgery and following surgery, along with the reactions of families whose responses to the patient's illness are bound to influence recovery. Physicians must have knowledge of how to handle the psychiatric emergencies that invade their office, how to deal with the problems of drug abuse and drug addiction, how to diagnose early psychosis, and how to manage the complications of mental retardation. In regard to the world of sexual vexations alone, patients usually turn to their doctor for advice regarding not only genitourinary abnormalities and veneral disease, but also family planning, marital friction, genetic counseling, sex during pregnancy, intercourse techniques and practices, abortion, sterilization, frigidity, dyspareunia, vaginismus, impotence, premature ejaculation, loss of libido, and sundry other troubles that invest their most intimate areas of living. It is the rare physician who knows how to deal with all or most of these difficulties *(Medical World News,* 1973).

This is a most unfortunate situation since it has long been recognized that the non-psychiatric physician is a key figure in the army of mental health professionals. (Draper, 1944; Alvarez, 1947; Overholser, 1948; Rennie, 1949). A sizable number, estimated between 50 to 70 percent, of the patients

seeking medical relief suffer from functional instead of, or in combination with, organic ailments. There is scarcely a single bodily organ or tissue that may not be influenced by emotional forces. Due to this, much attention has been centered in recent years on "psychosomatic" factors in physical disease. A virtual plethora of articles on emotionally determined somatic syndromes has appeared in medical journals that have stressed an organismic concept of the human being. The internist or general practitioner probably has an advantage over the psychiatrist in dealing with the common psychogenic ailments of patients because the internist sees them at an early stage when they are more susceptible to treatment and because he or she is more capable of relating symptoms to the somatic status.Indeed, Groom (1947) stated forty years ago that "only a small percentage of neurotic patients can be or need to be seen by the psychiatrist."

Vital for medical psychological counseling are the following:

1. Ability to diagnose and to manage emotional interferences with physical functioning.
2. Understanding of how to help the patient adjust to critical situations in one's life.
3. Sensitivity to unexpressed communications.
4. Acquaintance with some interviewing, relaxing, and behavioral techniques.
5. Recognition of positive ego resources in the patient.
6. Aptitude in guiding without moralizing.
7. Discernment of an evolving transference and other resistances that will interfere with a working relationship.
8. Sufficient self-knowledge to control negative countertransference—the inevitable contaminant of the physician's personal problems and prejudices.
9. Willingness to spend at least one-half hour with a patient on occasion to encourage and discuss deepest emotional concerns.
10. Possession of adequate information about community resources that may be helpful in the treatment plan.
11. Skill in referring the patient to a psychotherapist for further help when necessary.

The knowledge essential to these competencies is generally acquired in a casual and sometimes haphazard way in the forge of experience. It is rarely taught in medical school. Some help has been extended to the physician by a few postgraduate courses as well as by consultations with psychiatrists. However, such proceedings have not proven to be altogether beneficial. The usual complaints have been that the information imparted has been "too theoretical" or "too disorganized" to help resolve the everyday problems facing the physician in daily practice. Obviously, it would be helpful if some way were devised of bringing to the physician in an effective form psychological techniques of working with patients within the individual's experiential range and time limitations.

Actually, within the past decades a body of knowledge has accumulated in the behavioral sciences —including psychiatry, psychology, sociology, and anthropology— that has a crucial bearing on problems of physical illness and rehabilitation and that may advantageously be incorporated in the education of physicians. How to develop an efficient means of communication of pertinent principles and techniques is the pivotal question.

In line with this objective, the curriculum of practically every medical school now contains a sizable number of psychiatric courses. The aim of such courses is to prepare the medical student so that the student can deal intelligently and skillfully with patients as persons and to give each student a basic understanding of psychologic and social problems in relation to health and disease. These goals were accented in the *Report of the 1951 Conference on Psychiatric Education* (1952) organized and conducted by the American Psychiatric Association and the Association of American Medical Colleges. At this conference it was generally agreed that instruction in psychiatry be started during the first and second years of medical school. Since then an increasing number of medical schools have stressed behavioral and sociological factors in their curriculum. With improved undergraduate education, the physician's role in mental health may become more structured than it is today. Eventually the non-psychiatric physician may well become a major factor in the management of the bulk of psychiatric patients. Hardin Branch (1965) has remarked, "My own feeling is that the education of medical students in the management of psychiatric problems should be such that within the limits of the kind of practice which the student physician plans, he should be responsible for the specific psychiatric care of many of his patients."

After medical students graduate as physicians, the roles that they play in the community and the prestige that they enjoy in the eyes of their patients lay a groundwork for psychological helping. How a physician may function therapeutically in a relationship with a patient has been detailed in a number of earlier writings that are still valuable reading—for example, Whitehorn (1944), Rennie (1946), G. Smith (1946), Ebaugh (1948), Bartemeier (1951), and Watts and Wilbur (1952). Useful books for physicians on therapy are those on general psychotherapeutic techniques by M. Levine (1942) and interview psychotherapy by Law (1948). A very good account of the role the physician plays in mental health is included in the early volume by Rennie and Woodward (1948). Recommended books are those by Aldrich (1966), Balint (1957), Beliak (1952), Bennett et al, (1956), Castelnuovo-Tedesco (1965), Hamburg et al, (1982), Missildine (1963), Moench (1952), Nash et al, (1964), Tallman (1961); Thompson and Byyny (1983), Weiss and English (1957), and Zinberg (1964). Recommended also are the articles by Hulse (1950), Balint (1954, 1955, 1961a & b, 1965, 1966a & b, 1969, 1970a & d, 1972), Engel (1982), Orenstein and Goldberg (1972), Borus (1975), Hoeper et al. (1979), Rieger et al. (1978).

Recognizing that readings, while helpful, are not in themselves sufficient to inculcate adequate skills in psychotherapy, a number of postgraduate courses for physicians have been organized that rely on the case method of teaching. Perhaps the most noteworthy study here was that of the Minnesota Experiment set up by the Commonwealth Fund (Witmer, 1947) in which an attempt was made to introduce the most pertinent parts of basic psychiatric thinking into general medicine and included clinical practice under supervision. Ziskind (1951) described a training program introduced at the Cedars of Lebanon Hospital, a general hospital in Los Angeles, in which volunteer practitioners examined and treated patients with psychogenic problems under supervision of a staff psychiatrist. Ziskind felt that the uncovering of psychogenic conflicts was within the sphere of the practioner, although the latter was not qualified to do character reconstruction, which, an objective of long-term therapy, was reserved for the psychiatrist. In England, around 1950, at the Tavistock Clinic, Balint (1957) organized a full program for physicians that stressed the management of the doctor-patient relationship: "The aim is to make the general practitioners aware of what their patient wants to convey to them, not so much by his words as by his whole behavior, and how their own general behavior and actual responses influence what the patient can actually tell them." Other courses have been organized at the University of Kentucky and at Mount Sinai Hospital in New York City. The National Institute of Mental

Health has sponsored a number of programs in which approximately 11,000 physicians have been enrolled. A preceptership model of education, in which a psychiatrist comes to the office of a family physician, has proven of value in selected instances (Grotjohn, 1957; Brook, et al. 1966; Zabarenko et al, 1971). This format enables the psychiatrist to see at first hand with the physician the kinds of cases the latter actually handles. Teaching rather than consultation is the primary goal. Formal courses that have been organized range from simple lectures on drug dosages (a topic most acceptable to non-motivated physicians) to personal supervision of physicians treating patients with psychoanalytically oriented psychotherapy over a period of years (which is most applicable to a few physicians interested in working more in depth with patients). There are courses on psychiatric emergencies, attitudes of the physician toward patients, interpersonal relationships, and specific problems like alcoholism, depression, drug addiction, suicide, geriatric problems, marital discord, and other syndromes.

The Federal government, in the mid 1970s influenced perhaps by studies that have validated the effectiveness of psychological interventions in lowering hospitalization admissions and general medical care (Levitan & Kornfeld, 1981; Mumford, et al, 1982) mandated and supported training programs for residents and postgraduate courses for primary care physicians. Furthermore they provided tuition for those medical students who after internships or residency committed themselves to engage in primary care health services in the community. Federal assistance was also extended for the development of health maintenance organizations and community health centers in different parts of the country. Unfortunately Federal support for these programs has gradually been diminishing.

Models for the psychiatric training of residents in primary care programs have varied depending on the available funding, the sophistication of the administrative agencies, and quality of the training personnel (Pincus, et al, 1983). Some programs have stressed close liaisons with control by psychiatrists. Some have sporadically utilized psychiatrists in consultation and for random supervision. Others have employed in-house staffs of non-medical behavioral scientists as educators. The results have not been consistent, but progress has nevertheless been made in spite of the fact that mutual suspicion and distrust is still obscuring the relationship between a considerable body of physicians and psychiatrists.

Results with postgraduate programs for physicians in practice have not been completely successful. About 90 percent of the physicians say they simply have no time in their busy daily practice to engage in

further psychiatric education; some are frozen by hostility toward psychiatric practice and practitioners. Some who do respond favorably are primarily motivated by a need to help themselves with their own emotional problems. But those who sincerely engage in continuing psychiatric education report that they do benefit, thus substantiating the statement made in the Task Force Report of the American Psychiatric Association (Psychiatric Education and the Primary Physician, September, 1970), "because they are conscious of disappointments, failures, and mistakes in their practices and because they recognize the need for more understanding of emotional factors if they are successfully to treat, manage, and reform the patients they see." Most physicians do not desire to practice psychotherapy recognizing their lack of training and the fact that time spent in listening, guiding, consoling, advising, and counseling "is in fact the least highly rewarded activity in fee schedules." They do want information that will help equip them to diagnose, to handle temporarily, and to refer the kinds of patients they see in primary care and other settings. This may abate the fear some psychiatrists have expressed that primary care physicians will encroach on their territory. It can be seen from this that what is urgently needed are innovative training programs that enhance the competency of physician trainees (Borus, 1985).

One of the difficulties that is currently being investigated is why a mental diagnosis is not being recorded by primary physicians even when mental symptoms are recognized and psychotropic drugs prescribed. This may be due to inadequacies in the current diagnostic system or in physician knowledge and skills (Jencks 1985). It may also be due to reluctance to label a patient with a mental diagnosis in view of the fear the patient's being stigmatized by such a diagnosis.

A problem that seems to defy resolution is a continued prejudice against psychiatry. The 1961 Report of the Joint Commission on Mental Illness and Health brought this out and concludes that general practitioners as a group are not too interested in mental health problems. To cope with this resistance, the American Medical Association, in 1952, created a Committee on Mental Health to formulate policy. Its efforts resulted 9 years later in a planning conference in Chicago, and the next year (1962) the first AMA Congress on Mental Illness and Health focused its attention on 19 specific topics, ranging from undergraduate education to operational research. A second AMA Congress, held shortly after the first, limited its deliberations to the practicing physician's role in developing community mental health services. Helpful toward facilitating action has been the American Academy of General Practice (AAGP), which since 1956 has designed programs aimed at helping general practitioners become better

acquainted with psychiatric techniques. With a committee from the American Psychiatric Association, two colloquia were sponsored (in 1961 and 1963) for teachers of postgraduate psychiatric education. The Western Interstate Commission on Mental Illness and Health brought arranged a series of programs for non-psychiatric physicians that covered most western states. These were developed around the idea that it was essential to bring education to the physicians in remote areas rather than to expect them to travel distances in order to obtain schooling. Indiana University also organized "road shows" of traveling teams of teachers, who demonstrated a remarkable flexibility in adapting themselves to the needs of the physician groups being taught. A program of the New York Academy of Medicine also stressed the importance of gearing studies to the requirements and existing sophistication of the students. Beliak's (1963) course at Elmhurst illustrates the wide range of techniques that may be employed in teaching. These include didactic talks, films, tapes, small-group seminars, case presentations, and role playing, with the use of multiple teachers and special consultative programs.

It is generally agreed that lectures must be practical, structured, crisp, and well prepared. Short formal presentations are best followed by small-group seminars in which cases from the physician's own practice are discussed. The role of the doctor-patient relationship is a central focus.

A valuable contribution as to what to teach was made in the Indiana University questionnaire study, which listed in weighted rank order the following topics: drug therapy, techniques of short-term psychiatric treatment, psychosomatic conditions, interview techniques, adolescent behavior problems, handling psychiatric emergencies, obesity, childhood behavior problems, early signs of schizophrenia, care of the geriatric patient, marital counseling, depression and suicidal risk, emotional concomitants in medical and surgical conditions, premarital counseling, school problems, alcoholism, role of physicians in follow-up of released psychiatric patients, medicolegal problems, emotional problems of the involutional period, and juvenile delinquency.

Bilmes and Civin (1964), who organized a survey to determine the degree of interest in a program of psychiatric education for non-psychiatric physicians, have commented on this study: "That is a fairly comprehensive list. Allowing for regional differences (for instance, one might anticipate that in the New York City area, Juvenile Delinquency and Drug addiction—which ranked 25 in the Indiana study—would rank higher) perhaps the one serious question one might raise is whether what the physicians

want is exactly the same as what they *need*. Thus the doctor-patient relationship isn't cited even though, as mentioned before, it is one of the key points stressed by everyone planning these programs. Another important point is how much these topics can be gone into without the presentation of some fundamental theory—the theory of defense mechanisms, for instance. Another surprise is the omission of the subject of psychosexual problems. Organic brain diseases are also ignored in the Indiana survey—whereas, by contrast, a separate course in this area has just been started by the Nassau group."

According to Bilmes and Civin, their own survey indicated that physician-students "almost unanimously spontaneously stressed (the interviews were open ended) that they considered the demonstration of live psychiatric interviews plus ensuing discussion as the most powerful means of teaching psychiatric principles. They strongly cautioned against the dangers of being too abstract, too theoretical, and too analytical at the beginning. Several stressed the need to teach psychiatric nomenclature at the outset to make further discussion fruitful. A number added that if the teacher was good, almost anything was permissible and would be effective." The investigators recommended for a format the following: (1) A series of courses should be offered rather than one course with a fixed series of topics, the courses to be graded not only by subject matter but also in terms of basic versus advanced levels. (2) The most effective format appears to be once weekly meetings of one and a half to two hours, beginning with a short didactic lecture, then followed by small-group seminar discussions with a leader. Stress should be consistently on case material and, wherever possible, live presentation of patients—preferably by the registrants from out of their own practice. Some type of adjunct consultative service is advised as well. Theoretical material and areas of dispute should be shunned and only introduced when essential to the further explanation of the case material under discussion. (3) Announcements of the program and registration is best handled with the collaboration of local, established medical groups. (4) Instruction should primarily be in the hands of medical people with non-medical specialists introduced only gradually and, at first, as an adjunct service. Otherwise too much initial confusion, misunderstanding, and resistance would probably be elicited. (5) The subject matter should be comprehensive and in keeping with the needs various programs throughout the nation have found to exist in their physician population. (6) Though many such programs do not require a registration fee, those that do require it do not seem to have a worse registration because of it. Once the physician is interested in a particular program, he does not get deterred because of a fee. (7) Finally, means should be

provided to discuss with the participants their reactions to the program, whether it is meeting their needs, how the program can be improved, both during the actual running of the course and then afterwards as a follow-up study (Bilmes & Civin, 1964).

To evaluate the effectiveness of many of these programs, the American Psychiatric Association appointed a task force that published a report (American Psychiatric Association, 1970) intended as a guide for those interested in planning continuing education courses for physicians in psychiatry. The report stressed the small number of physicians interested in education: "The apathetic, uninterested, uninvolved physicians who do not enroll in programs continue to be a source of major concern to the Committee, particularly since they seem to comprise as much as 90 percent of the medical community in many areas." Recommendations are made for a small-group case approach in a dynamic setting "that provides an arena for group interaction and better communication, to focus on resistances that hinder physicians work with their patients and to resolve anxieties generated by specific cases."

Many problems superimpose themselves on the teaching of psychiatry to non-psychiatric physicians. Most doctors have neither the time nor motivation to go into any extensive program of study that even modest mastery of the subject would require. Nor is there a satisfactory body of knowledge of what to teach should a willingness to learn exist. What most practitioners wish to know are shortcuts on how to manage emotional factors that interfere with their patients' getting well. In a way the tranquilizers, and particularly the anxiolytics (Valium, Xanax, etc.), have been a dubious boon to many physicians since they immediately subdue complaints without complicated verbal discussions. This has served to lessen the educational fervor of even those physicians who recognize the contribution that psychiatry can make to medical practice. It eventually becomes obvious to the enthusiasts of drug therapy that medicinals are not a complete answer to the psychological problems of their patients and that in some instances they complicate rather than help difficulties.

It is important to emphasize that the training of the non-psychiatric physician in psychiatric principles and interviews does *not* make that physician a psychotherapist. The great majority of physicians are unable, unless they are unusually gifted and intuitive individuals—and have ample time in their practices for lengthy interviewing— to do more than to make a diagnosis, to do supportive counseling, and to motivate the patient to accept referral to a psychotherapist if this is necessary. Yet,

even with this limited role, physicians will find their work immeasurably benefitted through their awareness of psychological factors in illness.

The Teacher in Mental Health

One of the fundamental aims of education is to prepare the individual for the business of life and to equip that person for a proper role as a functioning unit of society. By and large, educational procedures have been successful in broadening intellectual horizons, but they have not been so successful in expanding the individual's capacities for productive human relationships. The concept that a healthy life adaptation is dependent upon a healthy personality evolved through a healthy milieu during early years has given rise to the hope that the school may be able to provide the student with experiences that can reinforce constructive factors and modify destructive factors in the home. According to Rogers and Sanford (1985) "Evidence, based on experience and research, support the opinion that the best of education would produce a person very similar to the one produced by the best of therapy."

Children spend a good part of their life in school, and they are subject, during a relatively plastic period in development, to the disciplines, injunctions, and pressures of the school authorities, particularly their teachers. The latter constitute an enormous untapped reservoir for potential mental health manpower. In addition to helping the child to acquire knowledge, teachers, for better or worse, "continuously are providing a lesson in how adult authority figures behave, providing a model for this child's future behavior, and altering the child's conception for better or worse" (Guerney, 1969). The teachers' personal conditionings with their own parents and resulting conflicts and defenses are crystallized in attitudes toward others and toward themselves, which will decide the standards of conduct expected from their pupils. These will determine the material the teacher selects in teaching, the manner and timing of rewards and punishments, and the willingness and ability to understand and to help children who are manifesting disturbances in learning, interpersonal relationships, and general behavior. Reaching out to the student in trouble when he or she needs the teacher most may register a lifelong impact. The desired objective is to initiate a feeling that the student is a person of worth. The teacher's incompetence in doing this may reinforce the child's distortions.

Perhaps the most significant aspects of school experience apart from the techniques of instruction

and the content of the curriculum are determined by the teacher's personality, skill in managing human relationships, and understanding of children. Where the teacher has severe emotional difficulties or is victimized by current stresses related to status or economic insecurity, these cannot help but influence the stability of the teacher's relationships with pupils. How best to behave and how to maintain equilibrium in the face of present-day school difficulties is a moot question for a teacher. What has been learned in basic training and psychological readings often melts in the firing line of duty. The more unstable the teacher's personality structure, the more anxiety precipitated by difficult and acting-out children in the classroom, the more problems may be expected.

A potent problem is defective motivation particularly in the more disturbed teachers, the press of finances, and disrupting social factors that bleed over into the classroom encouraging violence, delinquency, and involvement with drugs. Many teachers feel that they do well to hold onto their own sanity in the face of the contemporary turmoil. This is scarcely conducive to proper communicating and practicing of mental health principles.

There are few teachers who are adequately prepared as a consequence of their own teacher-training programs to function at top efficiency without further psychological knowledge or self-understanding. Testing the hypothesis that self-knowledge can improve teaching skills, Jersild et al, (1963) set up a research project gathering information from over 200 teachers who had exposed themselves to personal psychotherapy. The results indicated "a sweeping array of gains in self-acceptance and acceptance of others" and an enrichment of their personal lives that had a distinctive bearing on their personal work. Teachers who had undergone psychotherapy were better able to handle untoward personal emotions toward their pupils and "to disentangle their own feelings from the feelings and concerns of others." An interesting finding was that, contrary to what might be expected, the teachers did not consider themselves amateur psychiatrists and appeared to be more aware of their limitations than the control group in dealing with emotionally troubled students.

This does not mean that teachers must undergo psychotherapy to function adequately. Often the proper information about current developments in the field, part of an in-service program, along with some guidance and supervision by professional people may be all that is required. Some maladjustment in the teacher is not necessarily detrimental to functioning. The *kind* of maladjustment is the determining

factor. Fear of aggression will inspire undue anger, explosiveness, or retreat in the face of defiant behavior. Excessive competitiveness, such as that issuing from unresolved sibling rivalry, may bring the teacher into conflict with an extraordinarily bright child. Inordinate needs for control may inspire a crushing authoritarianism. Unresolved sexual problems and needs for parenting may encourage a pampering or babying of selected "pets," fostering their dependency. On the other hand, as R. D. Gladstone (1948) pointed out years ago, some maladjustment may make for greater empathy with the needs of students and a dedication to teaching tasks. It is important to realize that teachers will respond with countertransference to select areas of disturbance in their pupils, either overreacting or underreacting to them—for instance, to stealing, cheating, untruthfulness, disobedience, cruelty, destruction of school property, bullying, impertinence, resentfulness, obscene notes, truancy, defiance, masturbation, overcriticalness, unsocialness, suspiciousness, heterosexual activity, depression, sensitiveness, shyness, fearfulness, dreaminess, and puppy love (Thompson, CE, 1940).

That teachers, more or less, ignore problem children, and pay greater attention to and express approval of pupils who have the highest intelligence and academic achievement and the best personality adjustment, was shown in the study by deGroat and Thompson (1949). The children who need help most are consequently most ignored or rejected. Countertransference will also determine the nature of pupil teacher action for the good or bad. How changes in children's responses are determined by the atmosphere established by teachers was illustrated in the interesting experiment by Trager and Yarrow (1952) and by the studies of H. H. Anderson (1937, 1939; et al, 1945, 1946 a & b; 1954). Mussen and Conger (1956) emphasize the impact on the child of the teacher model and explain it in terms of behavior—social learning theory. The effect of a democratic as compared to an autocratic or laissez-faire atmosphere has been described by K. Lewin, Lippitt, and White (1939).

To some extent personal problems may be assuaged by bettering the conditions under which the teacher functions. This is especially the case where difficulties are contingent on status and economics. Salaries of school teachers are often so low that the best suited teacher will seek employment in other fields. The only applicants willing to take school jobs are in some communities those who are least qualified. Other problems relate to limitations in what is being taught. Some effect may be registered by changing the techniques of teaching and the content of the curriculum in line with mental health needs, by setting tasks and goals that are comprehensible and challenging to children, by helping them to clarify

perplexing problems and feelings that are parcels of everyday living, and by inculcating in them some understanding of the complexities of human relationships.

This does not detract from (indeed, it makes more urgent), the need to develop methods in the classroom that will hopefully neutralize the disorganizing forces of contemporary society. The skill of the teacher in the handling of human relationships, as has been mentioned, is a key factor. This may be enhanced where the teacher has a genuine interest in teaching and in children and is not burdened by too severe neurotic and realistic problems. Furthermore, the teacher may be able to acquire a greater understanding of the child and the child's needs through good personal undergraduate or postgraduate mental health instruction. Courses for teachers on human development, psychotherapy and psychodynamics, principles of counseling and interviewing, and group dynamics are important here. In a few instances group discussions, headed by a trained group worker, have been instituted for teachers in order to bring the teacher to an awareness of undercurrent attitudes toward children that may be inimical to the establishing of good relationships with them. Additional training of the teacher is considered important as much now as in the past toward adding mental health goals to the educational design (Wickman, 1928; Ryan, 1939; Watson, G, 1939; Zachry, 1944; Prescott, 1945; Berger, D, 1947; Baruch, 1948; Mathewson, RH, 1949; Trager, 1949).

Experiments in application of a mental health dimension in education were instituted years ago. In nursery schools (Allen, CM, 1947; Allen, WY, & Campbell, 1949), public schools (Tarumianz & Bullis, 1944; Commission on Teacher Education, 1945; Bullis & O'Malley, 1947, 1948; *Good Education for Young Children,* 1947), and colleges (Anderson, VV, & Kennedy, 1932; Angell, 1933; Anthonisen, 1942; Bernard 1940), programs incorporated in their content and method principles of mental health calculated to meet the emotional needs and to add to social development of the student. A number of conclusions were evolved from these experiments that have been incorporated into school programs (Association for Supervision and Curriculum Development, 1950) and are influencing modern experiments.

The recognition that emotional disturbances may sabotage learning and school adjustment has encouraged some teachers to attempt the diagnosis of emotional illness through observation of the child's behavior, attitudes, and performance. The average teacher is usually able to discern the more gross

symptoms of emotional disorder in such manifestations as hyperactivity, underactivity, emotional outbursts, undue restlessness, irritability, temper tantrums, drug involvement, violent rages, tremors, tics, nail biting, apprehensiveness, pervasive phobias, compulsive acts and rituals, speech disorders, reading disabilities, and writing difficulties. With special training the teacher may be able to recognize the less obvious signs of neurosis.

Where the child exhibits patterns of emotional illness and where these patterns have become so structuralized that they cannot be modified through a better school environment, therapy of some kind will be required. In a few instances a conscious effort has been made by the teacher to apply therapy to students who have been blocked in learning or who manifest conduct disorders and other problems in school adjustment. Thus, Zulliger (1941) utilized psychoanalytic formulations in treating conduct disorders. Axline (1947) believed that a teacher trained in nondirective therapy may be able to reflect back to the child feelings and attitudes that the latter is attempting to express and in this way inculcate insights into the child's behavior. She insisted that nondirective methods may be applied to teacher-administrator relationships. Her work has been substantiated by the reserach of Aspy and Roebuck (1983).

As to other types of interventions that teachers may utilize, these vary and certainly should be eclectic to provide choice according to the needs of the pupils and the level of training, the philosophies, and styles of the teacher. Published studies have detailed the effects of various methods (Torraine & Strom, 1965; Davis, 1966; Redl, 1966; Ringness, 1967; *ATE Yearbook,* 1967; *Journal of School Health,* 1968; Clarizio, 1969; Ekstein & Motto, 1969; Guerney, 1969; Farnsworth & Blaine, 1970; Bernard, 1970; Bower, 1970; Lawrence, 1971; Clark & Kadis, 1971; Tanner & Lindgren, 1971; U.S. Office of Education, 1972; Glasscote & Fishman, 1973; NIMH, 1972, 1973; Holmes, 1974; Kellam, 1974). Applications of learning thoery in the classroom particularly have sponsored research on the effects of social reinforcement on undesirable behavior with the shaping of new, adaptive responses (Zimmerman & Zimmerman, 1962; Horowitz, 1963; Wolf, M, et al, 1964; Becker et al, 1967; Hall, RV, et al, 1968; Thomas, DR, et al, 1968; Harris, FR, et al, 1969). The contributions of learning theory to modern education have also sponsored a more wholesome dimension in discipline, away from punishment for infractions toward control by positive rewards and encouragement.

How far a teacher may go in assuming a therapeutic stance with an emotionally ill student is a matter of dispute. There are those who believe a teacher can function in a psychotherapeutic role. Jersild (1966) for example has stated:

> I am convinced that the view that a teacher's role is incompatible with a therapeutic role (using "therapeutic" in its broadest meaning as a process of healing) has been accepted too readily. I think the compatibility of the roles depends more on the teacher's personality than on his status. It depends also, I think, on the teacher's goals, and on his awareness of what he appropriately can do, and what he definitely should not try to do in an educational setting where self-exposure can be more threatening and anxiety-inducing, at least at the beginning, than within the protected confines of individual analysis or the typical group therapy situation. I also think that in considering the therapeutic role of education in general and of the teacher in particular it is necessary to regard what is therapeutic as falling on a continuum, ranging from a modest degree of ameliorative self-discovery to the more pervasive and ambitious outcomes sought by a professional therapist.

Most authorities, however, contend that the role the teacher can play in formal therapy is extremely limited. Insurmountable difficulties present themselves to the functioning in a dual teacher-therapist capacity in the average class! While the pupil may establish a relationship with an understanding teacher that is therapeutic for the child, the teacher is usually unable to enter into a systematic therapeutic program. Nor does the teacher, even with special training, possess skills that would make more than a supportive approach possible. Therapy of emotionally disturbed children necessitates the services of specialists more highly skilled than is the teacher in diagnostic and treatment procedures. A number of teachers seek further training in counseling and psychotherapy, those with Doctor of Education degrees sometimes being accepted in certain postgraduate psychoanalytic training programs.

Consequently, it is recommended that a child requiring therapy, be referred to the guidance department of the school, the school psychologist, or a consulting clinic outside of the school setting. Guidance and counseling services at schools are most efficient where a professionally trained counselor or therapist is available in the school and where there exists an organized pupil-personnel program. The latter should ideally offer such services as educational counseling, vocational guidance, and work placement as well as health, social, and psychologic services. The counselor or therapist may supervise the guidance activities of those teachers who are capable of functioning in guidance with students.

As parents, school administrators, and governmental authorities become more enlightened and convinced of the advantages of a mental health approach in education, we may expect expansion of school guidance programs, an increase of diagnostic clinical teams within schools, and more clinics

outside of schools that can carry on whatever extensive therapeutic work is required. In the course of this expansion the teacher's preventive and therapeutic roles will undoubtedly become more comprehensive.

Recommended readings for teachers include the books by Abraham (1958), Allinsmith et al. (1962), Bower (1960), Caplan (1961a & b), J. S. Coleman (1961), Farnsworth (1957), Haring and Philips (1962), Jersild (1955), Kaplan (1959, 1971), L. S. Kubie (1961), Redl and Wattenberg (1959), D. Rogers (1957), B. K. Smith (1964), Torrance (1962), Wallin (1955), V. White (1958), and the U.S. Department of Health, Education and Welfare, Monograph 5, *The Protection and Promotion of Mental Health in Schools.*

The Minister in Mental Health

Frequently the first person consulted in times of emotional stress is a minister who occupies a position of trust in the community. Traditionally, clergymen and clergywomen are called on to advise and consult as well as to act as religious leaders. Their capacity to understand, to evaluate, and to manage the emotional problems presented to them are vital to the impact that they will make on the mental health of their congregation and community. Through community activities of the church (religious, social, recreational), as well as through preaching, clergymen and clergywomen can reach multitudes that have no other contact with a psychological resource. Gurin et al. (1960), qd in the Final Report of the Joint Commission on Mental Illness and Health, found that 42 percent of the people seeking help with emotional problems turned initially to the clergy. The solace the sufferer receives from such consultation may be great, due in part to the unique prestige that ministers occupy in the mind of the average individual. The ministers' potential mental health role accordingly has become increasingly recognized in recent times (Clinebell, 1965). They have been able to reach large segments of the population who for a variety of reasons (e.g., lack of financial resources, scarcity of trained professionals, language barriers, lack of sophistication in psychological matters, etc.) are unable to avail themselves of professional mental health services.

The problems brought to the attention of ministers are legion. Among those most commonly encountered are (1) marital problems, (2) parent-child problems and behavior difficulties in children,

(3) emotional instabilities, especially in young adults, and middle-aged men and women, (4) disturbing love affairs, (5) conflicts in adolescence, and (6) desire for information and help on problems involving education, social welfare, and mental health.

In recent years, it has been recognized by clergymen and clergywomen of all denominations that while religion often serves as a source of strength for people who are confronted with situations of crisis, it may require supplementation, even in the devout, in the face of anxiety and other manifestations of neurosis. As Martin (1965) states: "Again and again, in interviews with ministers of every major Protestant denomination in every part of the country, came this same sad confession of inadequacy. Whether he preaches from a rural pulpit or in the suburbs or in the inner city, the parish minister is a man assailed by the fear that he cannot effectively cope with the staggering human problems he encounters. And this sense of inadequacy breeds guilt." As a consequence, many ministers have become interested in obtaining a scientific understanding of human beings so as to increase their effectiveness in dealing with people in trouble (Burtness & Kildahl, 1963). It is pointed out that no real disparity need exist between psychiatric knowledge and religious belief (Farnsworth & Brace-land, 1969).

Recognition that many of the problems brought to the minister's attention are nurtured by emotional illness has led to the offering, in the training of divinity students, of psychiatric orientation courses. Clinical training for ministers in hospitals, prisons, and social casework agencies began in 1923 and was carried on two years later by the Council for the Clinical Training of Theological Students in New York and the Institute of Pastoral Care in Boston, and eventually through their training centers across the country. Later these two national groups formed a new organization, based in New York City, called the Association for Clinical Pastoral Education (ACPE). In addition, other national groups were organized such as the American Association of Pastoral Counselors (AAPC), the Mental Hospital Chaplains Association, and the College of Chaplains of the American Protestant Hospital Association. Each of these organizations required its members and training centers to meet at least minimal national standards of competence before certifying members or accrediting centers.

Some of the training programs have offered the student-minister opportunities for understanding problems in interpersonal relationships, the forces that enter into personality formation, the difficulties people encounter in adjustment, and the manifold reactions to stress. Students are taught methods of

working with people in trouble and the ways that they can cooperate with other workers, such as physicians, psychiatrists, nurses, social workers, and psychologists toward helping the emotionally disturbed individual. Awareness of problems in counseling, of the limitations of the minister in counseling, of resources to which persons may be referred, and of ways of handling the more common types of counseling situations are among the objectives in training. Most of the methods taught have been of a supportive nature, although the interviewing process, as described in some of the books and articles on pastoral counseling, have drawn a good deal from Carl Rogers' client-centered approach aiming at personality modification (Rogers & Becker, 1950; Hiltner, 1950).

A review of the training offered in mental health areas at seminaries and theological training centers reveals great variations in the quality and extent of psychological indoctrination. Elaborate lecture and field experience requirements exist in very few instances. Programs in clinical pastoral training have allowed theological students a measure of acquaintance with ministering to the sick and have helped them to gain a degree of awareness of their own reactions within the situation. Yet, most often, training in mental health aspects of pastoral work as related to the working minister's day-to-day counseling problems is either disregarded or limited to 1 or 2 semesters of human relations course on a preprofessional level.

A considerable advance toward the refinement of training in mental health principles was made possible through a 5-year grant that was extended in 1956 by the National Institute for Mental Health to Harvard (Boston), Loyola (Chicago), and Yeshiva (New York) universities for development of mental health material to be included in the basic curricula of seminaries training clergymen of all faiths. Interdisciplinary denominationally based efforts have led to clear definitions of the areas in which the most effective mental health intervention may be instituted by the clergy. They have helped to clarify religion's role in the area of psychological healing and have made recommendations for better curricula and teaching materials in the seminary training of the three major faiths (Herr, 1962; Hofmann, 1962; Hollander, FI, 1962; Hecht, 1965).

The rapidly growing rapprochement between the ministry of all faiths and the behavioral sciences has led to significant developments in three main areas: (1) organizations and journals have been founded to open up channels for communication and to provide space for discussion; (2) training goals

for ministers have been defined, pastoral counseling centers developed, and diverse training programs instituted; (3) lively controversy has developed about the professional identification and qualifications of the minister as counselor (now often called "Pastoral Counselor"). With the increased recognition of the minister's unique role in mental health, a considerable body of literature has come into being. Meissner (1961) qd 2905 references on religion and psychiatry. There are now many more. A variety of approaches to enhance the mental health training of the minister have been tested experimentally. With increasing frequency the terms "pastoral psychology" or "pastoral counseling" have been used to refer to the minister's mental health functions.

The Academy of Religion and Mental Health, chartered in 1954, "aims to bring together, for exchange of views and full collaboration, those who work professionally in the fields of religion and health." The academy merged with the American Foundation of Religion and Psychiatry, established in 1937, and became known as Institutes of Religion and Health. Among a series of journals established was the *Journal of Religion and Health* and the *Journal of Pastoral Care,* published jointly by ACPE and AAPC.

An area of agreement appears to have been reached early as to the desirable goals of training in pastoral counseling as enumerated, for example, by F. I. Hollander (1959):

> To enable them [the ministers] to recognize signs of mental illness and emotional disturbance among those who seek their aid and guidance and to refer such people to proper sources of help.
>
> To participate actively in mental health program on a prevention level for the benefit of the community at large.
>
> To gain an understanding of the psychology of the mentally ill, physical sick, and socially maladjusted for the purpose of more effectively helping such people through the media of ministration and pastoral counseling.
>
> To gain a better understanding of the psychology of normal growth and development for the purpose of utilizing this knowledge to convey more effectively those religious resources which can help people in their efforts to maintain a more mature approach to living.

The nature of the training process leading toward the achievement of such goals are still subject to experimentation. Some programs take into account the specific role identification and role definition of ministers and differentiate them, as the enabling persons, explicitly from the psychiatrist, psychologist, and social worker, as the treating persons whom they join on the mental health team. Yet, in other instances the training approach makes such a differentiation difficult, as candidates are subject to a

curriculum that only narrowly varies from curricula in psychoanalysis and psychotherapy.

Some programs are administered through theological seminaries. In such settings training is often directed at the student minister rather than at seasoned parish clergy and tends to emphasize varying denominational religious values and their contribution to and integration with mental health concepts. The accent at times is placed on the mental health effectiveness of religion rather than on the interpersonal impact of the religious representative (the minister). Other programs take place in hospitals, prisons, various treatment settings, and parishes, often in collaboration with the local mental health community. They range from short workshops and periodically scheduled conferences to more ambitious long-term efforts.

An adequate training program must consider the clergymen's and clergywomen's special position and identity, the image that they project, their assets and liabilities, and their special problems in professional and community living. It must clearly differentiate the mental health contribution that the clergy can make apart from that of the psychiatrist, psychologist, and social worker. It also must encourage and enhance meaningful team work collaboration with other concerned professions and disciplines. The training process must be geared toward helping the minister with the specific problems encountered daily among the people of the congregation, and it must consider the full spectrum of their emotional crises. The program must take into account the clergymen's and clergywomen's own emotional responses and must plan to help reduce their own anxiety by a better understanding of themselves and others. Finally, it must emphasize the opportunity to interact closely with colleagues of other faiths and denominations in order to broaden the self-understanding and personal possible prejudices and biases.

As an example, the training program in pastoral counseling at the Postgraduate Center for Mental Health in New York (Hecht, 1965) has evolved a number of training concepts that attempt to meet these requirements. The student body is composed of male and female clergy of various faiths. The entire faculty consists of certified psychoanalysts who are interested in working with religious leaders. Teachers and students form a team and interact closely over a period of 2 years. Cases presented in classes, supervision, and practice are those that the students encounter in their religious work. As part of an ongoing experience, ministers in training meet weekly in small groups with experienced group leaders for the duration of the training program.

Some concepts of pastoral counseling based on psychoanalytic principles have developed from this collaboration. Students practice a goal-directed ego-level approach, maintaining focus on a specific presenting problem. They elicit a matrix of dynamically relevant information (e.g., history, psychosocial development) against which they limit their exploration to the most manifestly bothersome conflict area. Dynamic insights are applied toward an appraisal of the nature, scope, and necessary disposition of the central problem on hand (e.g., suitability for counseling, limitations of goal, nature of referral when indicated). Contacts are geared toward maintaining an atmosphere of reality within a context of here and now. At all times the counselors are encouraged to remain conscious of their religious identity, to consider its impact on the situation, and to use it as fully as possible in the interpersonal encounter.

Inevitably, as more ministers become active in the mental health field and participate at different levels in mental health training, the problem of limitations of scope, of the establishment of a new specialty within the ministry, and with it the problematic delineation between counseling activities and psychotherapy become questions of considerable controversy. It appears that at this time the large majority of ministers in good standing with their denominations endorse training objectives that permit the minister to recognize and understand signs of emotional disturbance and that allow active participation in mental health programs and to gain a clear grasp of his or her limitations as well as potential participation and intervention in the work role.

The concept of a specialty of practitioners, "pastoral counselors," who may operate in private practice or at treatment centers outside of church settings and control has aroused controversy among prominent psychologically oriented churchmen (Hiltner, 1964; Oates, 1964) and psychiatrists (Pacella, 1966). The identity of ministers as "mental health professionals" in possible conflict with their principal roots and training as religious leaders appears not to have been resolved at this time.

In an attempt to shed light on this grey area, the *Journal of Pastoral Care* devoted its December 1972 issue to the publication of a research study supported by AAPC (Taggert, 1972) and of a symposium of leaders in the field of pastoral counseling, calling it, "Pastoral Counseling at a Crossroad." The contributions to the symposium reflect the prevailing state of controversy.

The Reverend Mitchell, Director of the Division of Religion and Psychiatry at the Menninger

Foundation, for instance, states unequivocally, "Pastoral counseling is not in itself a profession at all; it is an activity undertaking within the boundaries of a profession: ministry" (Mitchell, 1972). On the other hand, Cox (1972) writes, "In all honesty, I do not know whether the pastoral counselor has a place in the community as an independent autonomous practitioner." Oates expresses his belief that pastoral counselors could establish a professionally effective role if they were to communicate consistently their special knowledge in the fields of religion and ethics to the mental health professions, but he finds regretfully that they often do not do that (Oates, 1972a). Clinebell (1972) notes the temptations of private practice and possible national health insurance fundings for "health professionals" and sees them as potentially distracting from the clergy's major commitments.

It is perhaps unavoidable that rapid growth had to bring along its growing pains and that some abuses have occurred in certain fringe areas. The large number of highly responsible people from the religious as well as the mental health field who have committed themselves thoroughly to the measured and well-delineated development of the minister's therapeutic potential, testifies to the social usefulness of this training task.

Conflicts Between Religion and Psychotherapy

Inevitably, in considering the clergy role in mental health, the troublesome relationship between religion and other forms of healing comes to the fore (Pruyser, 1966). More and more it is apparent that a rapprochement between religion and psychotherapy is possible if each discipline respects the other's services and standards (Appel, 1959; Banks, 1965; Braceland, 1955; Doniger, 1954; Einstein, 1954; Hiltner, 1950; Liebman, 1948; Long, 1951; Loomis, 1963; Stace, 1965; Whitehead, 1925). There should be little need on the part of the pastor to undermine the goals of the psychotherapist, and of the psychotherapist to depreciate the effectiveness of the pastor.

A general consensus is that good psychotherapy will not alter the individual's faith, unless faith has been employed not as a genuine means of searching for meaning but as a neurotic defense, in which case faith will loosen itself from destructive anchors toward a more wholesome mooring. Psychotherapy does not depreciate religion or promote atheism. On the contrary, it deals with dimensions that can release the individual's spiritual promptings toward values that reflect or are identical with the virtues of religion.

Psychotherapy neither attempts to indoctrinate patients with the religion of the therapist nor to attack the religious beliefs of patients in whom religion acts as a constructive moral force. Patients accordingly, by being helped to tame impulses that are beyond their control, may emerge from psychotherapy with firmer and more illuminating religious sentiments. However, if their uses of religion are neurotic, they may in the course of psychotherapy evince skepticism toward the value for them of religion. Psychotherapy, thus, by exploring the neurotic employment that the patient makes of religion and probing his or her attitudes toward religion releases the patient to approach religion from a more mature perspective toward the expression of humanitarian impulses, not to appease an avenging deity but out of love and esteem for mankind.

It is said that no conflict should exist between psychotherapy and religion about in whose domain sin and guilt reside. The concept of sin and the emotion of guilt are both geared toward a properly restrained social functioning. The conscience—the repository of guilt—is a constituent of a person's psyche. Moral codes are vital for society's survival; it cannot exist without ethical and legislative canons. Guilt is an instrumentality that helps inhibit antisocial drives; it can however become excessively harsh punishing even normal behavior. Sin is a concept that designates certain actions as transgressions and sponsors the withdrawal of religious or social sanction for these acts. Ministers have sometimes accused psychiatry of forgiving sin and minimizing free will and moral responsibility. Psychotherapy does not seek to mollify essential guilt. But both guilt and the branding of actions as sinful can become pathological manifestations of a disturbed psychic and social organization. It seems that sound religion as well as sound psychotherapy can most often agree fully on definitions of destructive-sinful behavior and the importance of *rational* guilt feelings; similarly, they can agree on the underdesirability of *irrational* guilt and scrupulosity. Psychotherapy then recognizes the vital role of religion in helping to foster appropriate guilt and to designate antisocial drives as sinful. Nevertheless, it also considers that certain religious directives may sponsor abnormal guilt feelings and too easily label certain human desires as sinful. It is in these instances that psychotherapy must be concerned with the impact of such directives on the functioning and balance of the individual searching for help. It aids in the individual's freedom of choice between good and evil. It seeks to release the person from irrational guilt toward normal maturity.

The acts of turning to religion (conversion) and seeking salvation also point up areas of conflict between psychotherapy and religion. Personal consciousness of the need for salvation will enjoin many

persons to seek institutional outlets, such as those provided by religion, for its realization. A search for a sense of peace and unity may lead the individual toward moral restitution as a means of making the best use of one's life. The release of affective energy on the object of faith, the joyful ecstasy, lightheartedness, disappearance of perplexity, feeling of a new life, and sense of operating under divine control certainly have psychological components. Interest on the part of the psychotherapist in the act of converting to religion as a predictable phenomenon stemming from natural causes has led ministers to assume that psychotherapists bring their patients to doubt the entire conception of the nature of divine activity and to consider conversion an abnormal phenomenon rather than the bestowal of grace. However, irrespective of psychological and deterministic factors, psychotherapists recognize that conversion to religion and reaching for salvation are powerful resources toward which a burdened soul may turn for solace and peace of mind. Giving themselves up to a stronger power may be the only way through which certain patients arrive at a satisfactory adjustment. Though interested in neurotic reasons why a patient may seek the solace of conversion and salvation, and while he or she may consider it a responsibility to explore and work through neurotic defenses, the psychotherapist will not interfere with a patient's arriving at the decision that conversion to a faith is for him or her an appropriate objective.

Psychotherapy does not willfully set itself up as the arbiter of whether or not there is life after death, nor does it qualify to interpret the Scripture. These are matters for the theologian. The psychotherapist, however, does consider it important to determine the neurotic uses the patient is making of preoccupation with an afterlife and with various religious concepts that the patient presses into service for the exploitation of neurotic drives.

Recommended books for clergymen interested in mental health and pastoral counseling are those by M. K. Bowers et al. (1964), Braceland and Stock (1963), Brister (1964), Bruder (1963), C. A. Curran (1952), Hall and Gassert (1964), Hiltner (1952), Johnson (1957), Linn and Schwartz (1958), McCann (1962), Maves and Cedarliaf (1949), and Oates (1955, 1962), Zilboorg (1953).

Mental Health Aids and Paraprofessionals

The search for mental health services has been far above what present professional providers alone can supply. Filling the wide crevices of need has poured a river of human resources from the ranks of

volunteers and low paid workers. “They have many names: indigenous worker, incentive specialist, enabler, clinical assistant, expediter, advocate, ombudsman, semiprofessional, paraprofessional, mental health assistant, and new professional.” (Greenblatt, 1985). The diverse array of roles has been staggering: storefront managers, home visitors, tutorial and remedial assistants, homemakers, counselors, translators, activity and recreational program assistants, mental health advocates, community organizers, aftercare service planners, and purveyors of supportive psychotherapy. The employment of allied professionals and nonprofessionals in the mental health area has been justified by society’s effort to satisfy unmet mental health needs. Attempts to supply large segments of the population with guidance, rehabilitation, and therapeutic services must, of necessity, recruit workers who traditionally have been considered on the periphery of the psychiatric profession (Gerty, 1965; Rieff, 1964; Lief, 1966; Sobey, 1970; Castelnuovo-Tedesco, 1971). An obstacle to accomplishing this end was the idea sponsored by psychoanalytic theory that insight into one’s inner conflicts was essential before definitive help for emotional difficulties could be expected. As long as this concept prevailed, it was assumed that training in depth psychotherapy was essential and that this had to be restricted to those with an appropriate background in medicine, psychology, and psychiatric social work. The successes achieved by group therapy, nonanalytic approaches, behavior therapy, and milieu therapy, which rendered important help to victims of emotional illness without intensive historical and intrapsychic probings, have encouraged the evolvement of innovative methods that could be taught to an array of workers with adequate intelligence, motivation, and interpersonal sensitivities toward the goal of social rehabilitation for their clients rather than the reconstructive overhauling of personality. These workers are often indigenous to the community in which potential clients exist, and, knowing the prevailing environmental conditions and subcultural codes, they are often able to make better contacts with individuals requiring help than more highly trained professionals (Bloomberg, 1967). On a maximal level they operate as primary providers of service especially where they have been trained in behavioral approaches as in the treatment of substance abusing adolescents. On a minimal level they are able to act as a bridge between the client and the professional should more specialized services be required.

The focus on cost factors has also served as incentive toward encouraging entry into the field of less highly skilled individuals. Finally, realization that the medical “illness” model is not applicable to a bulk of community problems has sponsored experimentation with techniques oriented around educational,

behavioral, and social prototypes that better permit the use of helping agents with a wide variety of backgrounds.

Experimental programs have been set up to use stable but untrained volunteers with adequate motivation to render direct help to the client (Berlin & Wycoff, 1964; Nichtern et al, 1964; Rieff & Riessman, 1964; Riessman, 1964, 1965; Christmas, 1966; Felsenfield et al, 1966; Klein W, et al, 1966; MacLennan, 1966; Guerney, 1969). Included are citizens such as those interested in the Big Brother movement (Lichtenberg, 1969), high school students (Fellows & Wolpin, 1969), college students (Umbarger et al, 1962; Cowen et al, 1963; Reinherz, 1964; Brennan, 1967; Goodman, 1969), offenders (Hawkinshire, 1969), police (Bard & Berkowitz, 1967), and peers (Perlmutter & Durham, 1965; Buehler, 1966).

Parents have been trained to do "filial therapy" on their emotionally disturbed children under the control and supervision of a psychotherapist (Guerney, 1964, 1969; Hawkins et al, 1966; Andronico & Guerney, 1967; Johnston, 1967; O'Leary et al, 1967). Interestingly, a mutual change is brought about as a result of the guided interaction between parent and child. After a short period of training the parent or parents are usually capable of having play sessions with their children while observing their own and their children's reactions to what they are doing. Empathic understanding is thus facilitated. The therapist's emphasis is, as in family therapy, on the interactional difficulties of the family members rather than on the individual pathology of the child.

The rationale of training police to help manage family quarrels and other difficulties among people in the community resides in the fact that fully 80 percent of their time is spent on "social services" rather than catching criminals. Unfortunately trainers are often unable to project themselves into the position of an officer who is plunged amidst a violent and hysterical scene where immediate decisions are necessary. Information about psychodynamics and psychopathology are of little help in the firing line of duty. Knowledge of how to listen to family members, encouraging them to verbalize ("talking it out is better than acting it out"), how to reassure and calm frightened and aggressive people ("when you are sympathetic and concerned, people reach out to you for help"); when, how, and where to refer people for further aid and services are of utmost importance. To function like social workers and psychological counselors, a police officer requires considerable instruction. Small-group discussions focused on

simulating situations commonly encountered, with role playing, led by a mental health professional experienced in working with the police and who is cognisant of their problems and responsibilities, as well as by an officer who has been trained in techniques and has observed the results of interventions, are extremely valuable. During family quarrels, for example, the simple expedient of separating the combatants and interviewing each separately while seated helps to quiet the situation. The officer is taught to avoid taking sides and to shy away from participating in the brawl, at all times observing his or her own emotional reactions and desires to impose personal values on the combatants. Of vital importance is knowledge of the referral resources in the community. Bard and Berkowitz (1967) have demonstrated how effective a training program with the police can be.

Experience with Synanon for drug addicts, Alcoholics Anonymous for drinkers, and Recovery, Inc., for emotionally disturbed individuals has lent credence to the idea that people with certain types of problems can help other people with more severe forms of the same problems and that this effort is mutually beneficial. Some of the self-help programs act as informal training facilities so that the recipients of help eventually learn to become the dispensers of help. Whether they function as homemakers, recreation aids, youth workers, delinquency workers, or in other capacities, indigenous personnel usually are able to relate better to their clients than professionals from a different social and cultural setting. Young pupils have also been utilized as homework or reading helpers for younger pupils who are manifesting certain problems, with both parties sharing the benefit (Riessman, 1965). This principle of learning through teaching has many potentials. It goes without saying that adequate supervision is an essential requirement, particularly where a comprehensive training program has not been in effect.

Obviously, a great range of personalities, levels of education, experience, skills, and inspiration will be encountered whenever a therapist attempts to enlist the help of a nonprofessional person. The therapist has to adapt to the educational level and idiosyncrasies of the trainees, and, assuming that he or she is sufficiently skilled in community educational and consultative procedures, the therapist must act as a teacher and overseer. This supervisory role is not so easily accepted, particularly by professionals who are wedded to the exclusive medical model and resent the influx of workers from non-medical areas. Special training will be required for the therapists who seek to be a supervisor above and beyond their psychiatric, psychoanalytic, and psychologic education that will enable them to fuse mental health

concepts with sociological principles. In this way therapists can best contribute to nonprofessionals who work with people in various settings.

An important question relates to the kinds of patients and problems that are most effectively helped by the endeavors of the nonprofessional. No less important are the methods and techniques that nonprofessionals can learn and utilize with proficiency. Of great help is the fact that many of the complaints and afflictions encountered in the community are often expediently managed under the auspices of a sociological, reeducative, or rehabilitative model rather than a medical model. Learning irregularities, habit disorders, vocational difficulties, delinquency, perturbations related to extraordinary environmental stress, recidivism, and drug addiction are among the conditions that often respond better to counseling, educational, rehabilitative, and behavioral approaches than to traditional psychotherapies. The advantage of such auxiliary measures is that the objective of adjustment may often be rapidly achieved through the ministrations of personnel who may be trained without spending the years of graduate and postgraduate instruction that go into the making of a psychotherapist.

While gifted nonprofessional people, possessed of a natural empathy and capacity to inspire confidence, often function well in supportive and educative roles as helping agencies, how much further they can progress in doing depth therapy, even with further training, has been open to question. In 1960 Margaret Rioch (1963, 1965), a clinical psychologist, and Charmian Elkes, a psychiatrist, started a pilot project at the clinical center of the National Institute of Health to see whether "middle-aged, married women whose children are just about leaving home" could be trained to render therapeutic services. "By using them the need for more low-cost therapy can be alleviated and the mature woman's need to be useful can be filled… . Here is a gold mine of psychological talent."

Married women, all college graduates, were selected for the experiment of seeing whether they could within two years be trained to do psychotherapy, with certain limitations. Cases assigned ranged from mild ("adjustment reactions") to very serious emotional problems ("psychosis in remission"). The objectives in training were not simply milieu therapy. It soon became clear "that we were training our students for the practice of a profession… . The training was narrow but intensive and practical, and sharply focused on psychotherapy… . Participating in the program were psychoanalysts, psychiatrists, psychologists, and social workers, who all held quite broad, undogmatic points of view…. No one was an

evangelical disciple for a particular school of psychology. No one had the need to have a precious identity confirmed as a physician or psychologist."

In evaluating (Rioch et al, 1963, 1965) the results, a number of methods were employed including a group of examiners (two psychiatrists and one psychologist). The consensus of a group of examiners was enthusiastic. "I could think of an awful lot of patients that I would like to be able to refer to them [the trainees] and I wouldn't feel badly that they weren't going to see a psychiatrist." Following completion of training, all of the graduates were hired by community clinics, hospitals, and schools. "All of them intend to continue working indefinitely, possibly to add to the work force available in the mental health field by tapping a hitherto unused reservoir of capable people." Lawrence S. Kubie, summarizing the experiment, wrote:

> It has been my privilege to observe these trainees on three well-spaced occasions, starting a few months after they had begun their training in psychotherapeutic counseling. It has been a heartening and exciting experience to see how a group of mature women, who have gone through the stresses and turmoils of bringing up their own families, with diverse college backgrounds but no prior technical training in psychological disciplines, could, in so short a time, become thoughtful, astute, perceptive, sensitive, and patient psychotherapeutic counselors. If anyone needed it, there would be no better proof that this opens up an important new way to attack the bottleneck caused by the shortage of trained workers in this field.

Ten years after the project with the first group had ended the majority of the mental health counselors were engaged in full-time work at different institutions though chafing at the difficulty of achieving rewards concomitant with professional function. "We were paid less than traditionally trained workers; we were excluded from professional organizations; patients' insurance did not pay for our services; there were no civil service slots for us" (Showalter, 1971).

The reactions of this group are not extraordinary since creation of a new profession of psychotherapist has been brewing a storm of controversy. The eye of this hurricane is the lay person with no background in medicine, psychology, nursing, or psychiatric social work who seeks an identification as a "therapist." There is no argument with both the need for expanding therapeutic services for the multitudes in need of help by training more personnel nor the competence of adequately qualified nonprofessional participants who undergo proper instruction and supervision. In public clinics comprehensive regulations by State laws help prevent abuses. The problem lies in the less than properly qualified individuals who expose themselves to threadbare courses and seminars that lead them to

overvalue their abilities and to venture into risky zones of private practice far beyond the limits of their training and experience. Undaunted by the conservatism that is a hallmark of careful training, these eager neophytes, with exuberant faith in themselves, easily gather a coterie of impressionable clients and, exploiting the bounties of spontaneous improvement (Brill & Beebe, 1955; Saslow & Peters, 1956; Goldstein, AP, 1960; Endicott & Endicott, 1963) and the non-specific forces of a helping relationship, may deceive themselves into believing that they possess God-given talents as therapists. Testimonials from satisfied customers are not necessarily a proof of competence. What is forgotten, or perhaps not even noticed, are the dropouts from treatment and the relapses into illness after leaving treatment of those who were "successfully cured."

These unhappy contingencies do not detract from the potentially useful and socially constructive aspects of the training of nonprofessionals. The implications of such training for both the teaching of psychotherapy and for the staffing of clinics and hospitals are interesting. Can we revise our standards for training in psychotherapy in terms of (1) lowering pretraining requirements, (2) abbreviating the course curriculum, and (3) shortening the length of training? What will be the effect of training of mental health counselors in psychotherapy on the professionals now practicing in the field? What will happen when the number of counselors gets great enough to encourage the organization of a special society dedicated to the protecting of their interests in the field? What about the independent private practice of such counselors of psychotherapy as they realize that the rewards of private practice are greater than those afforded by working in institutions? The problems now being experienced between the medical and non-medical groups will undoubtedly be compounded unless attitudes change or new laws are formulated—contingencies that in themselves pose many dilemmas and quandaries.

It may be expedient to mention that nonprofessionals may make valuable contributions to the training and the functions of professional mental health workers since they are often in closer and more prolonged contact with special patient populations, such as those engaging in substance abuse and other addictions, and come from many of the same kinds of backgrounds and environment. Intelligent par&professionals are thus better able to translate patients' cultural and subcultural group values, behaviors, linguistic metaphors, nonverbal cues, and conceptual frameworks into their own language. They also know more practical ways of solving problems, which are often peculiar to their community and which can be utilized in executing the treatment plan (Talbott et al, 1973).

THE CONCEPT OF TEAM FUNCTIONING

In many psychiatric clinics the traditional mental hygiene team, consisting of psychiatrist, clinical psychologist, and psychiatric caseworker, is no longer considered the preferred therapeutic framework. Changing conditions of practice have altered this conception to that of a constantly changing team membership and shifting leadership. The professional responsibility of each team member is defined, and a base is provided for mutual interaction and the pooling of skills. The team is regarded as a group of specialists or consultants, each playing a specialized role as well as having some sort of therapeutic function. In addition to the three professionals mentioned, other professionals are sometimes employed, on staff or consultatively used in the clinic varying with the cases that are being treated. Thus, teachers may be utilized for reading and writing disabilities, speech therapists for stuttering, physical therapists for special losses of function, nurses for organic ailments and disabilities, and rehabilitation workers for chronic mental illnesses. The traditional specialized operations of the conventional team members in a community psychiatric clinic are delineated in Table 16-1. In recent years psychiatric nurses have been constructively added to the regular team, especially in agencies where day care facilities are available. Because of the shortage of psychiatrists, as well as the high costs of psychiatric consultation that the clinic cannot afford, there has been a breakup of the usual lines of command, non-medical professionals assuming some of the roles that in the past have been an accepted and exclusive part of the psychiatrist's functioning. A non-psychiatric physician in consultation for such things as the prescription of medications has been used with variable results when a psychiatrist has not been available.

Table 16-1 Traditional Specialized Functions of Various Team Members in a Community Psychiatric Clinic

Psychiatrist	Caseworker	Psychologist
1. Establishing a psychiatric diagnosis	1. Intake interviewing (clarification of services to prospective patients and determining if services are consonant with the needs of the patient)	1. Diagnostic testing: intelligence, educational achievement, vocational, projective personality tests.
2. Physical examination where needed	2. Preparation of patients for psychotherapy, dealing with resistances to treatment and establishing the proper motivation for treatment	2. Exclusive handling of, or acting as consultant for:
3. Neurologic examination where the psychiatrist is qualified	3. Exclusive handling of, or acting as a consultant for, problems in patients relating to finance, health, employment, recreation, housing,	a. Problems of school adjustment, maladjustment and placement.

	exercise, companionship, and special training. Acquainting patients with, and aiding them to utilize most effectively, available community resources	
4. Administration of somatic therapy (drugs, ECT, etc.)	4. Acting as a casework consultant to other team members where environmental manipulation in their patients is essential in addition to psychotherapy.	b. Corrective work in educational field; therapy of reading or other educational disabilities.
5. Arranging for commitment and hospitalization where necessary	5. Acting as a liaison between patient and the family, employer, teacher, etc. when it is essential to interpret patient's illness to them, to give them reassurance, or to enlist their interest and cooperation.	c. Career planning, vocational guidance.
6. Handling routine physical and neurologic check-ups on patients with physical and psychosomatic problems	6. Handling of parents, mate, or children of patients who are being treated by team members and who require counseling or psychotherapy as an aid to the treatment of the patient.	d. Rehabilitative work for physical and sensory defects particularly in educational and vocational areas.
7. Handling of psychiatric emergencies, such as severe depression, suicidal tendencies, excitement, psychotic manifestations etc.	7. Handling of children with primary behavior disorders.	e. Speech disturbances.
8. Supervision of non-medical therapists in the management of emergencies.	8. Organizing and handling administrative details of educational projects of team. Interpreting the work of the clinic to the community; securing cooperation of the community in the work of the clinic. Acting as a liaison between the clinic and community organizations that are implementing community programs related to health, welfare, and social security.	3. Organizing and handling administrative details of research projects of team.
		4. Behavioral techniques and bio-feedback.

In clinics headed by psychiatrists and dedicated to the medical model, the background training of the psychiatrist, and the affiliation with the discipline of medicine, is presumed to place the psychiatrist in the best position for the assumption of responsibility for the total treatment of the patient. The medical model dictates that the psychiatrist may utilize ancillary workers, usually clinical psychologists, psychiatric caseworkers, and psychiatric nurses while retaining medical responsibility. These precepts, however, as has been mentioned, are not always followed, particularly in agencies that do not have a

psychiatrist as a full time staff member and merely call in a psychiatrist for consultation.

Modification of the team model is, in summary, the order of the day, but occasionally one may come across vestiges of its survival.

In some psychiatric clinics a routine history is still taken by the social worker who has had no training in therapy. The social worker, during this process, observes the motivations of the patient for therapy, not in a deep dynamic sense, but in terms of what the patient says on a surface level. This enables the worker to evaluate why the patient comes for help and what is expected from the clinic. The very process of giving information in the social history helps the patient to be relieved of certain immediate anxieties. In discerning the motivations of the patient and the misconceptions that he or she may have, the worker has a good opportunity to explain to the patient how treatment can help a specific problem.

The particular aspect of the case history stressed by the social worker is the patient's social situation, especially the interpersonal relationships within the family, and disturbing aspects in the home. In the event that the patient decides to accept treatment, the social worker will be able to utilize this information in helping to relieve environmental pressures, provided the therapist decides that the adjunctive services of a social worker are required.

Another function of the social worker in such clinic setups is to help prepare the patient for psychotherapy, where, for various reasons, the patient is not yet ready to enter into a treatment process. In instances where the patient has already started therapy but does not have adequate motivation, the therapist sometimes sends the patient back to the social worker for further preparation. The attitude the social worker assumes is friendly and supportive, in the hope of clarifying the situation and perhaps helping the patient to see what it is he or she actually wants from the clinic. Another basis for referral to the social worker is for counseling and casework. Here there is a differentiation of psychotherapeutic functioning, the social worker doing supportive therapy where needed, and the psychotherapeutically trained personnel doing deeper educational and reconstructive therapy.

In carrying out supportive therapy, the social worker may not insist on regular appointments but rather will see the patient at any time. If personal visits are not made, a relationship may be attempted

either by telephone or by letter. Contacts of this type may eventually develop in the patient a desire for more intensive treatment. If the social worker is not equipped to carry the patient in deeper therapy and the latter requires further help, the social worker may send the patient back to the psychotherapist in the clinic or to resources elsewhere for help. In clinics where no intensive supervision is provided for the psychotherapists, patients who exhibit severe resistances may be referred to a social worker. The worker here attempts to evaluate with the patient what has been going on, with the object of making a reassignment of the case to another therapist should this be necessary. If the patient stops treatments with the therapist, the social worker may attempt to work out the problems that have developed between the patient and the therapist. The psychotherapist may employ the social worker as a co-therapist for patients who require some kind of environmental manipulation in addition to psychotherapy.

The social worker, furthermore, helps in any necessary referral of the patient to other agencies. Where members of the patient's family require clarification about the patient's problems or where they need help themselves, the social worker enters into the situation, sometimes taking over the management of the disturbed relative.

The clinical psychologist, who is untrained in psychotherapy, is employed in a clinic of this type to administer diagnostic batteries like intelligence, educational achievement, vocational, and projective personality tests. He or she is used as a consultant for difficulties in school adjustment and placement, for corrective work in educational disabilities, for vocational guidance and rehabilitation, and for research designing, execution, and administration. Clinical psychologists who have had special training in behavioral techniques or biofeedback, may be called on to utilize these.

Sometimes, following those patterns of the old-time clinic, the psychologist and the social worker have conferences related to the problems of a single patient. The psychiatrist contributes information about medications and differential diagnosis; the psychologist brings up an evaluation of the patient from a psychologic point of view, including projective testing; and the social worker helps round out the picture with an account of social problems in the environment and the family structure. Occasionally, the three team members operate jointly, as, for instance, where the patient requires vocational placement and rehabilitation. The psychiatrist here attempts to identify the sources of the patient's difficulty as related to the work area. The clinical psychologist administers a battery of tests, including vocational

interest and aptitude tests. The social worker helps with social problems that are linked to the work area. In work placement the psychologist continues to do vocational guidance, while the psychiatrist treats the patient as a whole. Where group therapy, family therapy, and milieu therapy are parcels of the clinic's operation, all team members may work jointly on a patient or family, assuming the team members have been appropriately trained.

This type of teamwork was, and occasionally now is, especially employed in child guidance clinics where the treatment involves not only dealing with the child's personality, but a manipulation of the environment. Interviews with the child's parents and other members of the family are held individually, jointly, and with the child. These are often beneficial especially where the child's disturbance is provoked by interaction with those around the child. The child may be treated by one of the team members, for example, the psychiatrist, while the the parent is handled by a non-medical therapist, for instance, the caseworker. Consultations between the two therapists, and with the psychologist who does the necessary testing, result in a coordination of the therapeutic program. In most clinics there is no hesitation to call non-medical interventions "psychotherapy," justifying this by saying that the therapist is operating under medical supervision. In some clinics trained and untrained non-medical therapists carry the bulk of the therapy with both parents and children.

Teamwork, such as has been described, is not employed in psychiatric clinics where the function is primarily psychotherapy with adults. This is because the interference of another team member in the treatment program may adversely influence the therapeutic relationship. If psychologic testing is required, nevertheless, the patient is referred to a clinical psychologist. Should environmental difficulties arise, the therapist may attempt to work out with the patient adequate ways of dealing with the problem. The therapist may perhaps consult with a social worker in order to learn of available resources in relation to a specific social need. Having this information at hand, the therapist may then attempt to help the patient utilize essential resources, by working out resistances to a particular plan of action.

In some clinics following a general screening by the intake social worker, the psychiatrist does the initial interview and provides answers to the following questions:

1. Are there any medical problems that should be referred to a medical practitioner or specialist?

2. Are there any neurologic problems that should be treated by the psychiatrist or referred to a neurologist?

3. Are there any existing psychiatric problems, such as suicidal tendencies, severe depression, excitement, antisocial proclivities, alcoholism, drug addiction, psychoses, or emergencies that require immediate attention, sedation, hospitalization, or electroconvulsive therapy?

4. Are there potential psychiatric problems that will need constant observation?

5. What is the diagnosis?

Thereafter the case may be assigned to the team member best qualified to treat the patient. The psychiatrist is selected where severe psychiatric problems prevail. Non-medical therapists are chosen where there are disturbances in vocational, educational, social, marital, and personal adjustment. Sometimes an attempt is made in case assignment to differentiate between "social" and "medical" psychologic problems. Non-medical therapists are assigned to simple situational maladjustments, personality disorders, and behavior disorders. Medical therapists are assigned to syndromes characterized by a breakdown in defenses and adaptation with severe symptom formation. The syndromes here are acute alcoholism, drug addiction, psychosomatic ailments, active psychoses, neurotic and psychotic disorders in organic and neurologic conditions, and traumatic neurosis. This differentiation of social and medical psychologic disorders is, however, artificial inasmuch as the individual is involved as a totality, and every one of the functions—somatic, psychic, and behavioral—are influenced in any emotional illness. Consequently, except for dangerous psychiatric problems, all types of emotional ailments are assigned in some clinics to non-medical therapists, provided they are sufficiently experienced and operate under competent supervision.

The subject of supervision in psychotherapy is complex and often befogged in competitive professional rivalries and semantic confusion. Actually, several forms of supervision are employed. There is, first, the general supervision of medical problems *(medical supervision).* Second, there is supervision for detection of medical and psychiatric emergencies and for problems in diagnosis (psychiatric supervision). Third, there is supervision of the psychotherapeutic process itself, the relationship

between patient and therapist *(psychotherapeutic supervision).* The first type of supervision may be rendered by a good internist. A psychiatrist, while qualified for the second type of supervision, may have neither the inclination nor the skill to look after the medical problems of the patient. Nor may the psychiatrist be qualified to supervise the psychotherapeutic process. A physician who has had exclusive analytic training and has drifted away from medical practice may not be the best person for medical and psychiatric supervision. In some clinics a highly skilled non-medical therapist may be used for psychotherapeutic supervision. In certain cases a non-medical therapist may, due to training lacks, be able to do no more than counseling or supportive therapy. More likely the therapist may be qualified to do reeducational psychotherapy, and, if trained to do reconstructive therapy, to do intensive psychotherapy, under whatever supervision that may be required. These rules also apply to the psychiatrist whose training may qualify him or her merely to do supportive therapy. Where there has been further training, the psychiatrist may be able to do reeducational and reconstructive therapy under whatever psychotherapeutic supervision is indicated by his or her experience.

Once a case has been assigned, psychiatric supervision of the non-medical therapist may be provided. The psychiatrist may designate the intensity of supervision, its frequency, and the mode of checking on existing or potential medical, neurologic, or psychiatric emergencies. No satisfactory system of reporting has yet been devised that can result in constant and complete psychiatric supervision of all patients in psychotherapy. In many clinics psychiatric supervision is spotty for many reasons, e.g., shortage of available psychiatric help, inability to afford such services, resentment of non-medical people at what they consider being put into unnecessary overseeing by the medical profession. With the continuing shortages in psychiatric personnel, and expanded training of psychologists, social workers, and nurses in psychotherapy, the quantity and quality of psychiatric supervision has declined.

When one examines the practices of representative clinics in relation to the matter of psychiatric supervision, one finds great variation. In some instances the non-medical therapist spends at least one hour weekly with the psychiatrist, bringing up problems that occur in the total case load. This presupposes that there has been sufficient training to make the therapist aware of cases that show signs of impending somatic, neurologic, or psychiatric difficulties. In many clinics the lack of psychiatrists has resulted in a spotty kind of psychiatric supervision, in that the psychiatrist is called in for consultations whenever, in the opinion of the non-medical worker, a psychiatric consultation or medication is

required.

Inevitably, staff working with individuals under emotional stress are drawn into some kind of a psychotherapeutic relationship. Because of this, many clinics have set up in-service training programs calculated to help develop the skills of their clinic personnel. One of the problems here is that the specialized training in psychotherapy of the various team members tends to divorce them from the roles usually identified with their profession. Thus, the physician doing psychotherapy may give up interest in general medicine, may lose diagnostic medical skills, and eventually may feel unqualified to do a good physical and neurological examination. Most psychiatrists for this reason refer patients who require medical attention to internists. The clinical psychologist tends to become removed from testing, often on the basis that a psychotherapist functions more on a sophisticated level. The clinical psychologist, too, may lose testing skills and will refer patients requiring testing to another clinical psychologist. The psychiatric social worker doing psychotherapy often resents doing casework and may want to give up identification with the profession. In some instances the psychologist and caseworker may even drop their professional titles and insist on being called "psychotherapists." Many therapists, as soon as they have become sufficiently skilled, are lured by motives of economic betterment into private practice. This creates a difficult situation for the clinic and makes it more of a training than service resource.

Notes

1 There are, of course, many agencies that are not typical in this sense but are "primary" casework agencies in the sense that caseworkers administer the agency and carry the main treatment load. Psychiatrists, psychologists, and other professionals are used as consultants in such agencies. They are also more purely treatment agencies in the sense that need for their services is defined primarily by emotional breakdown. Many child guidance clinics and family service agencies fall into this category. The typical caseworker does not work at such an agency, however. The practice of a caseworker in such a setting is akin to that of a psychotherapist.