An Asocial Psychology and a Misdirected Clinical Psychology

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ABSTRACT: The origins of modern clinical psychology cannot be understood independently of some longstanding, dominant characteristics of American psychology in general. One such characteristic is psychology's emphasis on the individual organism, an emphasis that ill prepared psychology in the post-World War II period for the public arena. One of the consequences for clinical psychology was that it became embroiled in the traditions of American medicine. The adverse effects of this are explored and discussed.

In what social-historical context did the major features of modern clinical psychology initially gain expression? How did this context affect the universe of policy alternatives modern clinical psychology could have considered in its early phase? Why did clinical psychology so readily accommodate to a public policy that not only defined what the "mental health problem" was in our society but also outlined how that problem was to be approached? And why did the basis of that approach in an individual psychology go unexamined? It is the last question that interests me the most because I have come to believe that from its inception a hundred years ago, American psychology has been quintessentially a psychology of the individual organism, a characteristic that however it may have been and is productive has severely and adversely affected psychology's contribution to human welfare. I elaborate later on this point, but those who may want to delve more deeply into this question I urge to read the APA publication edited by Hilgard (1978), which contains addresses of presidents of the association, beginning with William James. With one notable exception one would hardly know that psychology existed in a particular society having a distinctive social order deriving from a very distinctive past, that psychologists did not (and do not) represent a random assortment of people, and that by virtue of their socialization into their society, and their social-professional niche in it, the substance of their theories had to reflect these factors. Instead, one finds a riveting on the individual organism. The one notable exception, and it is a dramatically instructive exception, is a presidential address given in 1899 in New Haven with the title "Psychology and Social Practice." If psychology (then and now) had been able to understand this address, which was quite critical of the directions psychology was taking, American psychology would not now be suffering the malaise it is.

I have recently completed a book, Psychology Misdirected (Sarason, 1981), that is dedicated to the APA president who gave that address: John Dewey. Psychologists think of John Dewey, when they think of him at all, as an educator and philosopher who once was a psychologist. But Dewey saw clearly what psychology still is blind to: The substance of psychology cannot be independent of the social order. It is not that it should not be independent but that it cannot be. But American psychology has never felt comfortable pursuing the nature and consequences of the social order. Let the other social sciences wrestle with such matters! Besides, a true understanding of the social order, as well as efforts to change and improve it, could only come after psychology illuminated human nature, individual human nature. Psychology had it backwards, a fact to which it cannot be sensitive as long as theories are about individuals—as single individuals, as individuals in a dyad or small group, or as individuals in a family. For all practical purposes, social history and the social order were ignored. And this explains why when psychology really entered the "real world" and the arena of public policy in the post-World War II period, it was, from my standpoint, the beginning of a disaster. I must now turn to elaborating on these
points by reflecting on the history of modern clinical psychology. This introduction has been necessary if only to underline the point that the limitations of clinical psychology inhered in American psychology.

**Consequences of World War II**

Modern clinical psychology was a direct outgrowth of World War II. At all levels of federal government during the war, there was recognition that the government would have responsibility for a staggering number of veterans who in one way or another would be physical or mental casualties. That the government “owed” these casualties the best kind of care was clear, and the best kind of care would have to be quite different from that provided veterans in the decades after World War I. To provide this care would require a policy that would facilitate the placement of facilities and services in or near medical centers. That policy was intended to create a partnership between the Veterans Administration (VA) and the medical centers, the bulk of which would be university based. The VA wanted the quality services the medical centers could provide, and the medical centers needed the new facilities for training and research. No one raised the possibility that given the traditions of medical centers, especially their professional preciousness and imperialistic ambience, partnership would, in practice, mean domination by the medical centers. It was a policy that assumed that self-serving professionalism would not be a problem. It was not a policy rooted in the sociology of professions in general and the medical profession in particular. Indeed (as I discuss later in relation to clinical psychology), one of the characteristics of the policymaking process is the absence of sensitivity to social history. But there was an even more fateful, implicit assumption to the policy: Veterans would get “better” in the hospitals and clinics and then return to their homes and communities. That assumption contains a kernel of truth in relation to physical illness, but if I had the time I would have no difficulty demonstrating that from the standpoint of prevention of personal, family, and work problems, this kernel of truth is not all that impressive. In relation to psychological problems there is no kernel of truth. By their very nature these problems are individual–family–work–community related. In fact, as the VA learned in subsequent decades, hospitalization and clinic visits that focused on the intrapsychic dynamics of the individual were frequently counterproductive or simply ineffective.

Another important stimulus to the formulation of a policy for casualties of the war was an economic one, not only in terms of money for facilities and personnel but in terms of payments to veterans depending on their degree of war-incurred handicap. I am not attributing unworthy motivations to the policymakers when I say they were quite concerned that many veterans would seek to obtain payments from the government disproportionate to their handicaps and that some would manufacture symptoms to be eligible for payments. In short, there was the potential for an adversary relationship between the veterans and the professionals in the medical centers who would have to render judgments about degree of disability. This, of course, raised the question, Whom did the professionals represent? The potential for conflicts of interests, as well as for self-serving actions, was obvious on all sides. If what was obvious was not taken seriously, it was in part because everyone assumed that money would not be a problem, that the VA budget would increase to meet needs. So what if some veterans were getting benefits they did not merit? It may be somewhat unfair to say that the policymakers envisioned an endless gravy train. It is not unfair to say that they were naïvely ahistorical in the extreme in adopting such a stance toward the future. It took less than a decade for the professionals to learn that they were enmeshed in a system which put serious obstacles in the way of their therapeutic efforts and raised ethical–moral questions the professionals did not know how to deal with, except by getting out, which many began to do.

Unless one lived through those early post-World War II days, it is hard to appreciate the role of money as an incentive to medical center departments to enter the partnership. In the case of psychiatry, which up to World War II was not a strong or prestigious part of medical schools and medical centers, the VA presented a fairyland of delights: new facilities, additional personnel, residencies to enter the partnership. In the case of psychiatry, which up to World War II was not a strong or prestigious part of medical schools and medical centers, the VA presented a fairyland of delights: new facilities, additional personnel, residencies paid for by the government, consulting fees for faculty, research budgets, and all else that makes for gracious living. There are no grounds for questioning the sincerity of departments of psychiatry insofar as helping veterans was concerned. There are grounds for saying that the VA medical center tie presented psychiatry with the opportunity to become more influential vis-à-vis other specialties. And it is also true that departments of psychiatry did not see this tie as an end in itself but as a means
whereby other non-VA activities were made possible. Noblesse oblige characterized psychiatry's stance, which in practice meant, as it does in some legal partnerships, that there was a general partner and a limited partner. Guess who was the limited partner? The economics of the VA medical center reinforced the imperialistic traditions of American medicine, resulting in battles among medical departments and in "foreign" wars with "allied" health fields centering around resources, status, and prerogatives.

One could ask me, "Assuming you are even partially correct—about not getting 'better' in a hospital or clinic; about the consequences of personal troubles for family, community, and work; about the self-serving actions that money (a lot of it!) as an incentive played into—why didn't the policymakers know these things? Did they know them but in examining alternative policies find none that had fewer pitfalls?" To answer these questions requires that one ask and answer the question, Who were the policymakers? In a formal, flow chart, descriptive sense this is not an easy question to answer, but in terms of informal process and power the answer is clear: The "official," legislatively sanctioned policymakers were mightily influenced by representatives of university medical centers who were in high positions in the armed forces during World War II or who were called in as consultants. Their sincerity was as unquestioned as their ability to dispassionately consider alternatives was lacking. On the surface it might seem that their support for a VA—medical center relationship was blatantly self-serving; after all, they were advocating a policy that would pour millions of dollars into their institutions. The self-serving feature was there, but it should not obscure the fact that academic psychiatry saw itself at the threshold of a new era, as leaving behind the aridities, superficialities, and sterile biologisms of prewar psychiatry for a new psychiatry that was "dynamic," "deep," and effective. Psychoanalysis became legitimated by academic psychiatry, which meant that the analytic-training institutes—religious in attitude and ritual, desperate to become a recognized medical specialty, uncomfortable and silent about Freud's position on lay analysis, and disdainful of those who did not accept Freud's truths as interpreted by institute-anointed ayatollahs—added an ingredient quite compatible with the medical profession's attitudes of preciousness, exclusiveness, special social status, and tradition-conferred leadership role.

All that I have said so far can be summarized as follows: Health policy for veterans, formulated in terms of medical concepts, practices, and traditions, sought to interrelate two organizational cultures—the university medical center and a large, complex federal bureau. Neither of the organizations had experience with such a formal interrelationship, and neither attempted to understand the other's culture and what that presaged for their future relationships. It was a policy that stemmed from a process amazingly devoid of serious consideration of alternative approaches; it was a medical policy in terms of who would be responsible for implementation and what the nature (and language) and where the site of diagnosis and treatment would be.

Concern and responsibility for veterans was only one of the ingredients that helped usher in the new Age of Mental Health (Sarason, 1977). World War II was truly a world war, and it was a long one. No one in this country was unaffected by the war. For millions of people family life was disrupted as one or more of a family's members (sons, fathers, close relatives) were gone for months or years, died, or came back a casualty or stranger. And many who remained at home also changed and were as strangers to the returning veterans. It was a mammoth upheaval that accelerated the pace of prewar, socially centrifugal forces of change. In films, novels, plays, and radio dramas there was a common message: As a result of the war, the world, and everyone in it, would never be the same. That was "good" because it meant that the opportunity to build a better world was at hand, but it also raised the question of whether people were appropriately prepared for the coming changes. Although the end of the war was greeted with ecstatic relief, it was also accompanied by anxiety about another economic depression, the readjustment of veterans to civilian life, and whether the government could move quickly enough to mount programs that would head off social unrest.

By saying that World War II ushered in the Age of Mental Health, I am trying to reflect several facts. One was the influential role of mental health professionals in the corridors of power and policy, roles undreamed of in the prewar period. If they gained such roles, it was in large part because there was in the larger society an inchoate consensus that the frequency of personal problems had escalated and would continue to do so. If the incidence of personal breakdowns among veterans during the war was disturbingly high, if the incidence would increase with war's end as veterans returned to
civilian life, it followed that a large segment of the civilian population would be subjected to disabling stress. A health policy for veterans alone would not be adequate to deal with the nonveteran population. Viewed in this way, it was obvious that a crash program to train more mental health professionals would be needed. But, the mental health professionals said, there was not only a shortage of personnel but a shortage of scientific knowledge about the causes and treatment of personal disorders. What the government had to do, they said, was to support basic research. If the atomic scientists had contributed so much to the successful prosecution of the war, it was because they were able to exploit the findings of basic research. What the government had to recognize was that in the coming decades the frequency of disabling personal problems would emerge near or at the top of society’s problems and unless more basic knowledge about human behavior was obtained, there was no telling what the consequences would be. These were the considerations that led to the annual increases in the budget of the National Institute of Mental Health (NIMH). The mental health professionals promised a lot, wanted a lot, and got a lot. I need not elaborate on the fact that psychiatry dominated in the formulation of NIMH policy and obtained the largest fraction of financial support. The social sciences were deemed important but in terms of expenditures, not all that important. In the case of NIMH training grants for clinical psychology, they were dispensed by criteria which required that clinical psychologists obtain their field training in medical–psychiatric settings.

The Age of Psychotherapy is another way to label the post–World War II years. From the standpoint of psychology as a field, it really began with the publication of Rogers’s (1942) Counseling and Psychotherapy, a book that had quite an impact in and beyond psychology. This book was truly a pioneer effort, and I in no way intend to devalue it when I say that from my standpoint its consequences for clinical psychology and public policy were unfortunate. For one thing it defined (and made extraordinarily interesting) the problems of people in terms of an individual psychology: Problems were personal or narrowly interpersonal and for all practical purposes independent of the nature and structure of the social order. The mode of treatment was an individual one, which started a lively controversy about the comparative efficacy of different modes of individual treatment. Psychotherapy became the mental aspirin and people flocked to get the credentials to dispense it. The problem for public policy was how to train enough psychotherapists to deal with the people who needed them. But that problem ran headlong into another policy issue: Who owned psychotherapy? This issue is implied in the title of Rogers’s book because if counseling and psychotherapy were basically the same, medicine and psychiatry could not claim, as they did, that these were only in their domain.

Anyone who lived through those days will testify to the vehemence and resources with which organized medicine and psychiatry fought to keep others from their turf. Organized psychiatry was faced with a problem in large measure of its own making. It had helped formulate and promote a public policy that recognized the need for clinical psychologists in the psychiatric setting, albeit in a subordinate role. But in terms of the overwhelming need for psychologists in these settings, on what basis could one deny clinical psychologists a therapeutic function? And even if one wanted to restrict psychologists to a diagnostic and research role, how could one deny them a function that would make those roles more cogent and effective? The battle was waged on legal, professional, and social grounds. It was also waged on financial and status grounds because about the only thing that was clear in the smoke of battle was that in the psychiatric setting there was a near perfect correlation between salary and status, on the one hand, and who did how much psychotherapy, on the other hand. But one other thing was clear: Psychiatric–medical settings were not created by and administered for nonmedical personnel.

One would be very wrong if one interpreted all that I have said as a diatribe against medicine and psychiatry. But one would be right in interpreting what I have said, albeit too briefly and oversimplified, as a way of describing characteristics of the culture of American medicine in our society. It is a culture that socializes its members to view themselves and others in isolating ways; it cannot countenance challenges to its conceptions of leadership; it is quintessentially clinically oriented in contrast to a preventive orientation; it operates on the principle that what is good for medicine is good for the society; and it is almost totally lacking in the sense of social history that makes one humble before the fact that as individuals and collectivities we are inevitably prisoners of time and place, that self-interest and public interest should not be assumed to be identical, that how self-interest is defined depends on where one is in the social order,
and that to transcend time and place, even in small part, requires that one put into words what the socialization process, because it was so effective, made it unnecessary to verbalize. I could, of course, say many positive things about American medicine, but to understand public policy in regards to illness—which means how, as a professional culture, it tries to influence the use and direction of society’s resources—one has to look at American medicine in terms of its traditions, institutional structures, rites of passage, and economic base and interests. It is trivializing the issue to discuss it in terms of the “good guys and the bad guys,” a Manichean view derived from an individual psychology that leads to premature moralizing.

The Narrow Direction of Clinical Psychology

Now let me turn to clinical psychology and why it took the directions it did. What factors led it, unfortunately from my standpoint, to become embroiled in the culture of American medicine and psychiatry? To do justice to this question would require writing a book. Here I briefly discuss only a few of the major facets of my answer. To begin, the clinical tradition had a very flimsy base in pre-war American psychology. At best psychology was acclinical in orientation; at worst, it was anticlinical. That is to say, psychology had no experience with what was involved in training clinical psychologists, with the creation of settings for clinical practice, and with the culture of existing settings devoted to clinical service. It was a Johnny-come-lately to the clinical scene. When, as a direct result of the experience of leading psychologists during the war, as well as of the stimulus provided by an emerging federal policy, psychology sought (and was sought) formally to enter the clinical scene, it self-consciously had and proclaimed two assets, one major and one minor. The major asset was its research traditions and sophistication. The minor asset was embedded in psychology’s role in the testing movement. I call it a minor asset because the area of testing was never in the mainstream of American psychology, but was a tributary, and also because so much of what went on in testing was either nonclinical in goal or very superficially clinical. (It could be argued that, major or minor, psychology’s contribution to the testing movement has had negative consequences for society.) These two assets were also highly regarded by psychiatry, which, in propagandizing (used here nonpejoratively) for a new public mental health policy, emphasized the need for research on diagnosis and treatment. Psychology may have come late to the scene, but it was cordially welcomed. It presented no challenge, conceptually and institutionally, to psychiatry. Psychology would be part of the team. There was no question about who would captain the team and where the game would be played.

I must digress here to mention another asset, far more subtle than the first two, that was fateful for the future. It was an asset (more in the nature of a mixed blessing) that was as overlooked as it was obvious, but it had the kind of obviousness the significance of which could only be appreciated if one looked at psychology in terms of its institutional placement and culture. I refer to the fact that psychology was an arts and science discipline, not a professional one, in the university. It had successfully fought for and obtained an independent status in the university, which is another way of saying that it was constituted of fiercely independent individuals encouraged to do and used to doing things their way. The socialization process in graduate education inculcated the values of autonomy and no-holds-barred pursuit of knowledge. The spirit of accommodation, let alone subordination, was not in the picture. Of course, this spirit was not in the picture in psychiatry and medicine either. Two subcultures were on a collision course, but like in so many partnerships and marriages, the characteristics that can produce collisions are rarely confronted despite their obviousness.

From the standpoint of psychology, the tie that was being forged between clinical psychology and the psychiatric setting was a socially responsible one. Psychology saw itself as meeting social needs in ways consistent with and enriching of its own traditions and knowledge. What was also attractive about this tie was that it would be financially underwritten by the federal government, meaning that students would be supported, faculties enlarged, and consultantships arranged. Were it not for federal policy and funds, would clinical psychology have forged the tie that it did? And if this question had been clearly raised, the truly important policy question for psychology would have to come to the fore: What was the universe of alternatives that psychology, in general, and clinical psychology, in particular, should consider in deciding how they could best contribute to what was defined as a staggering mental health problem? This was the question psychology had to ask in arriving at a policy. But the question was never seriously raised for several reasons. One is that
psychology had no conceptual and research tradition in regard to policy formulation. Psychology had a long tradition of research on problem solving, but the significance of this tradition for the process of policy formulation was not seen. Another reason is that psychology, no less than psychiatry and medicine, was a baby-in-the-woods when it came to understanding the history and nature of government. This is but another way of saying that social psychology had never come to grips with the history, culture, and organization of American society. Social psychology was social in the sense that it was riveted on individuals and interactions among them: the attitudes individuals brought with them and the ways attitudes changed as a consequence of the interactions. It was social in the sense of having an interpersonal or a small-group focus. It was not social in the sense of placing these interactions in the context of a highly differentiated society with a distinctive culture and ideology that were reflected in and reinforced by governmental, political, educational, religious, and financial (profit-making) systems of institutions. This is the point that John Dewey made in his presidential address to the American Psychological Association in 1899 (see Hilgard, 1978). It is a point also made by Brown (1936) in his book *Psychology and the Social Order*, a heroically systematic effort to conceptually integrate Marx, Freud, and Lewin and a massive indictment of academic social psychology as well. Brown’s book was the only social psychology text of the time to deal with the significance of the Great Depression. And more than passing mention must be made of Dollard’s (1935) *Criteria for the Life History*, a title that unfortunately does not reflect what Dollard was about, which was to examine case descriptions of major theorists to see how seriously they took the concepts of culture and social order in relation to socialization and development. Dollard (1935) wrote,

A life historian, sophisticated in the above sense, can see his life history subject as a link in a chain of social transmission; there were links before him from which he acquired his present culture; other links will follow him to which he will pass on the current of tradition. The life history attempts to describe a unit in that process; it is a study of one of the strands of a complicated collective life which has historical continuity. The fact that an individual believes his culture to be “his” in some powerful personal sense, as though he had thought out for himself how to do the things which he actually does by traditional prescription, will not impress the observer who has the cultural view. He will regard this conviction as unimportant and will stress the point of uniformity of the subject’s behavior with that of persons who have lived before him and who now live in the same group. In such a “march” of a culture through time the individual is seen as less than a phantom; in point of fact, the individual only appears in times of crisis when the mores are not adequate to meet some real life situation which the group faces.

We are stressing at this point the fact that the scientific student of a human life must adequately acknowledge the enormous background mass of the culture; and not as a mere mass either, but rather as a configured whole. Before any individual appears his society has had a specific social life organized and systematized, and the existence of this life will exercise a tyrannical compulsion on him. Seen from this point of view the problem of the life history is a statement of how the new organism becomes the victim or the resultant of this form structure of the culture. Each life history that is gathered will be a record of how a new person is added to the group. It will be a case of seeing “the group plus a person.” To state the point in an extreme manner we can think of the organic man as the mere toy of culture, providing it with a standardized base, investing its forms with affect but creating very little that is new alone or at any one time.

If our life historian is not equipped with the above criterion he will certainly fall into error by referring to accidental, whims of individuals, or organic propulsion, much that is properly seen only as a part of the society into which the individual comes. These errors seem so chronic and immortal in social science thinking that it is hard to overdo the necessity of a very schematic statement of the cultural view. Many individuals who are quite able to state the point, after one fashion or another, are persistently unable to work it through into their manner of dealing with problems. One of the marks of an effective grasping of this point is the stated or implied “in our culture” whenever one makes any point in connection with individual behavior; it is a good thing to get into the habit, for example, of saying “men are more able than women to exhibit aggressive behavior in our culture.” One might venture that to the social psychologist the three most indispensable letters in the alphabet are I.O.C. (in our culture). (pp. 15-17, italics added)

Although Dollard found the clinical case descriptions inadequate by the criteria he employed, it would be a mistake to see his book only as a contribution to the clinical area. A close reading would convince the reader that Dollard—a sociologist, psychoanalyst, anthropologist, and psychologist—was indicting an asocial and acultural psychology.

It is hard to overestimate the consequences for clinical psychology of the lack of a foundation in a social psychology oriented, at least in part, to the nature of American society. There was nothing in American psychology that would have put on clinical psychology’s agenda the role of women, the social class bias of the mental health movement, a similar bias in connection with all health services,
the history of racial, religious, and ethnic discrimination, and perhaps most bothersome of all, the lack of a self-consciousness among psychologists that they were largely male, white, economically secure, and urbanized. One would be hard put to find evidence that in those days psychology knew that millions of people still lived in rural areas; one would be pardoned if one concluded from this that rural people were psychologically more hardy than their urban counterparts.

I said earlier that in serving as a matchmaker between clinical psychology and the psychiatric-medical setting, psychology was trying to meet the needs of society in ways that would be mutually beneficial. If this is true, how then can one explain that so many departments favored the tie with the VA even though their students would not see children or women? From the standpoint of theory and practice, as well as of the generality of research findings, how could psychology benefit from such parochialism? There are two parts to the answer: Psychology did not explore the universe of alternatives available to it, and few things rival money on the table in its capacity to short-circuit imagination. A fettered imagination impoverishes awareness of the universe of alternatives. Psychology was so focused on the money behind the proposed programs—in part because it served both narrow and socially desirable goals—that it totally failed to ask the question, If there was no money powering the invitation for clinical psychology to become part of the medical-psychiatric team, would psychology have moved in that direction? I submit that the failure to ask and examine this question was the hallmark of psychology's naiveté about itself and the social world in which it was embedded. The fact is that clinical psychology could have taken directions different from those it did. I am not saying that these directions were equally desirable and practical but, rather, that they were options that could have been considered. I could argue that from the standpoint of tradition and expertise, it would have made little difference which direction (or combination of directions) psychology took; it would in any event learn as it went along. It could, of course, have done nothing, as was the case in Canada, where after World War II psychiatry helped form a public policy that had no need of clinical psychology.

I would not be stressing the concept of the universe of alternatives if I did not believe that tying clinical psychology to the psychiatric setting was a major mistake from which clinical psychology continues to suffer. Clinical psychology became part of a medically dominated mental health movement that was narrow in terms of theory and settings, blind to the nature of the social order, and as imperialistic as it was vigorous. At least three generations of clinical psychology students became veterans of the war with psychiatry. Many had service-connected disabilities, but rather than ask for benefits, they preferred to leave and stay away from the battleground. There were more local battles and more Versailles-like peace conferences than some of us care to remember. And, of course, the superpowers—the American Psychological Association and the American Psychiatric Association—took over and the local skirmishes were eclipsed in importance by superpower collisions in the courts, the legislatures, and the executive branches of state and federal government. Wars rarely, if ever, have the consequences the combatants envision. Clinical psychology did not fight the war to become like psychiatry (as it is now tending to be), that is, exclusive, money oriented, a lobbying force, supersensitive and superpious about upholding standards and monitoring credentials, and tolerant but not respectful of the research endeavor. It is a classic case, if I may momentarily resort to an individual psychology, of identification with the aggressor, a process as revealing as it is unconscious. I do not say this sneeringly but, rather, despairingly. By tying clinical psychology to the psychiatric setting, both sides put themselves on a collision course with each other. Clinical psychology—the young David to the big Goliath—needed more than a slingshot. It had to show that it was more protective of the public welfare, more concerned with quality, more concerned with credentialing and standards. The war was fought on psychiatry's grounds around issues primarily determined by the medical and psychiatric traditions.

The Significance of the Boulder Conference

And now I must turn to the 1950 Boulder Conference (see Raimy, 1950) that was so fateful in determining the directions clinical psychology would take. Boulder was fateful not because it moved clinical psychology in new directions, but because it legitimated an orientation that had already been established during and immediately after the war. Boulder was sponsored by the Veterans Administration and the National Institute of Mental Health, a not unimportant fact because it
indicates what outcomes were expected, if not in detail then in broad outline. As conferences go, and they rarely really go, Boulder was exceptional in terms of length, seriousness, level of intellectual discussion, and pursuit of goals. There was an unusual self-consciousness about the fact that a new field was being shaped which would impact on society and psychology as a field. The outcome was not surprising in terms of tying clinical psychology to medical–psychiatric settings, but this was not because the conference discussion did not permit challenges to its main thrust. It was as open a conference as has ever been held. Every criticism and reservation I voiced earlier about tying clinical psychology to the psychiatric setting was explicitly brought up at the conference.

I was at the conference as a young, upstart, non-tenured associate professor who was inevitably in awe of the well-known, influential psychologists who were there. During graduate school at Clark University, I had had an externship at Worcester State Hospital, which was one of the few places (in my opinion, the only place) where there was real intellectual substance to what was then clinical psychology. But I also learned at Worcester State Hospital what it meant to be a second-class citizen in a psychiatric setting. If I had any doubts on this score, they evaporated after I took my first job at a new educationally oriented institution that had no psychiatrists and the superintendent of which, an educator, had been appointed over the most strenuous objections of the medical community. So coming from these experiences to Yale, and representing Yale at Boulder, I had strong convictions about tying clinical psychology to the medical–psychiatric setting. We were, I believed, not only asking for trouble but walking into a fight with chin out, hands down, and blurred vision. Why must the internship be in a psychiatric setting? Would psychology be capitalizing on its research traditions if clinical students were unsophisticated in psychotherapy? How could one justify the clinical emphasis at the expense of a preventive orientation? Would not psychology be more responsive to societal needs if it made a commitment to the public schools? Why should clinical psychology be tied to a setting that would not expose its members to such areas as mental retardation, criminality, physical handicap, and vocational planning and adjustment? Why was the curriculum that was being outlined weighted in favor of such elective courses as neurophysiology, pharmacology, and neuroanatomy? These issues were raised and joined, and the outcome was predictable. Only a handful of people at Boulder took the position I did. I do not think I ever expressed it at Boulder, but I know the following thought crossed my mind: If the funding for the development of clinical psychology was coming from other sources with no strings attached, would clinical psychology move in the direction it was going? In some vague way I knew that the conference was not confronting the age-old maxim that the hand that feeds you is the hand that can starve you, that money as an incentive is almost always powerful and frequently and unwittingly corrupting. And by corrupting I mean that dependence, in whole or in part, on a funding source facilitates rationalizations that constrict one’s thinking about alternatives more congruent with one’s initial values, expectations, and capabilities. The problem is made more difficult when one is part of a professional field, the internal policies of which reinforce the tie with the external funding source.

By virtue of the nature and details of the origins of modern clinical psychology, it is not surprising that one of the characteristics of its development has been concern with achieving independence from and a kind of parity with psychiatry. This concern catapulted the field into the arenas of politics, legislation, lobbying, and public policy. It was a move to gain and preserve independence, not to change the conceptual substance of mental health policy. It was a move to be considered as good as and as financially deserving as “them.” It was not a move that challenged the underlying conceptions of public policy, for example, its focus on the individual organism deriving from an asocial psychology. Nor was it a move that stemmed from an attempt to identify past conceptual mistakes but, rather, one that recognized past organizational mistakes. Self-scrutiny has never been a notable characteristic of professional organizations. I should amend this statement, however, by saying that professional organizations do scrutinize their political–organizational mistakes, but only when their status is threatened. The recognition that a field may have based itself on faulty conceptions of the nature of its subject matter always reflects sea-swell changes in the society, impacting on the field along a time dimension quite different from our usual experience of time.

Now to an instructive anecdote that illustrates how we can be unfortunate prisoners of time and place unless our education builds into us schemata that aid us in taking distance from our time and place. One not only has always to say “in our culture” (Dollard, 1935) but to add “at this time and
place." This anecdote relates to a future condition that already existed in the present but to which no one was paying heed. If the cast of characters had had the conceptual tools to help them divorce themselves from the compelling quality of their concrete present, clinical psychology might not have made the kinds of commitments it did. The anecdote is about a meeting that took place either shortly before or shortly after the Boulder Conference. I do not remember the point of the occasion or the names of most of the dozen or so people who were there. I do know that there were representatives of university clinical training programs and staff from the regional and central VA offices. At one point a VA staff person said, "Do you realize that the young veterans we are talking about will someday be old veterans, and we have a lot of those now from World War I, and we will not have the appropriate knowledge or facilities?" Nobody, including myself, responded to his comments and the meeting went on, probably to rehash the problems of training clinical psychologists. But it is as if his words were seared on my brain. I knew that what he said was important, but it took years for me to appreciate the wisdom of his words. I would like to believe that he understood, like no one else at the meeting, the difference between preventive and clinical thinking. His totally unintentional comments were, of course, confirmed in subsequent years: The VA is now responsible for more geriatric cases than any other societal agency—responsible but unprepared.

The point of the anecdote, thus, is that after World War II a health policy was being forged that was narrow in scope, not grounded in an attempt to conceptualize the nature of society and its social order, amazingly ahistorical, and resting on the belief that the future would be a carbon copy of the present. It was a policy forged by professionals who had no way of asking, How are the ways we are defining problems and modes of attack a function of where we are in the social order? How should awareness of our place in the social order serve as a warning that we are subject to certain biases and distortions in regard to our society and its needs? How does our place in its social order—the result of a host of selective factors which interact with a distinctive, prolonged education that emphasizes how different we are from the rest of society—prevent us from recognizing that, like it or not, we are part of the problem because we are in the stream of social history? One cannot ask these kinds of questions without being realistically humble. Humbleness is not a word that easily comes to mind when one reviews the mental health movement after World War II. Personal, intellectual, and professional arrogance comes more quickly to mind. The roots that clinical psychology had in American psychology were shallow, but they at least contained the fertilizing ingredient of skepticism. But that ingredient came only from an individual psychology, and it was (and still is) inadequately sustaining when psychology, in general, and clinical psychology, in particular, entered the arena of social reality and public policy. In those arenas a psychology is a mammoth distraction.

The therapeutic endeavor needs no justification, but when that endeavor becomes nearly all-encompassing in focus and policy, one must suspect not only the crippling role of parochial thinking but also the failure to examine and confront the nature of the society itself. A clinical psychology not rooted in a realistic social psychology—that is, a social psychology which sees itself as a cultural and social-historical product and agent, which sees itself by virtue of time, place, and social and institutional status as both a cultural cause and a cultural effect—is a misdirected clinical psychology. This point has been recognized by others of my generation who grew up in clinical psychology and none has said it better than Cowen (1980) in his recent stimulating article on primary prevention. Cowen is too realistic to be other than humble about our knowledge of how to approach primary prevention. As a clinician he knows how a part of us, as individuals, needs and treasures our symptoms, and as a community psychologist he knows how refractory our communities have been and will be to efforts at primary prevention. He also knows that going the route of primary prevention will illuminate not only important features of the social order but also how those features will be obstacles to mounting effective programs in primary prevention. And he also knows that psychology will vigorously resist changing its dependence on an individual psychology.

I sense a breeze of change in psychology's air. The October 1979 issue of the American Psychologist, a special issue, was devoted to "Psychology and Children: Current Research and Practice." One of the articles is as incisive as it is brief. It was written by an eminent child developmentalist, William Kessen. Kessen's (1979) comments about what is wrong in child psychology are similar to what Cowen and I have said. American psychology, invented in and by American society, went on to invent its subject matter: the self-con-
tained individual. The necessity for reinvention is at hand. Necessity may be the mother of invention, but let us never forget that inventions are rarely unmixed blessings.

Nothing in what I have said, and nothing in what Cowen and Kessen have said, denies that individual psychologies have contributed to our knowledge of human behavior and development. And, it should go without saying, nothing in what I have said in this article should in any way be interpreted as subordinating one approach (e.g., biological) to another. It is precisely the subordination of one approach to another that I have argued against. Anyone who is familiar with the past and current status of departments of public health in medical schools—or the sad fate of departments of community medicine—will be familiar with the adverse institutional and social consequences of subordinating one approach to another in the health area. Human illness and misery have diverse sources within and without the individual. If only because of this glimpse of the obvious, we must radically reexamine how we conceptualize the individual organism. This reexamination is crucial if we are to deepen our understanding and direct more effectively our capacities to prevent and repair.

The shortcomings of extant psychologies would not have been exposed in the way they have if psychology had remained a narrow, university-based, and encapsulated discipline. But the world—our entire, globe-straddling social world—changed and psychology was drawn into it as never before. To understand individuals for the purpose of influencing or helping them is one thing. To understand and influence social orders for the purpose of influencing parts of them is another thing, even if what one seeks to influence is a particular service to individuals. Ultimately, both types of understanding and the actions derived from them have to be conceptually interrelated because in the real world they are interrelated. The shortcomings of clinical psychology were inherent in those of American psychology. By emphasizing the shortcomings of clinical psychology, I have run the risk of blaming the victim. My aim has not been to blame victim or aggressor because to do so would be to trivialize the matter by resort to what Mills (1959) called unwarranted and misleading "psychologisms" deriving from an individual psychology. There is a creeping sense of malaise in psychology about psychology. But that malaise is not peculiar to psychology. It is suffusing the atmosphere in all the social sciences. Indeed, in some of the social sciences, like economics, there are those who not only believe that the emperor is naked but also that he has a terminal disease. But this kind of medical metaphor, however apt it may seem, is but another example of how our thinking is imprisoned in an individual psychology.

REFERENCES