Where We Are and Where We Need to Go: Getting Away from Professional Psychology's Sado-Masochistic Marriage to Academia

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Historians tell us that when Machiavelli was on his death bed the bishop came to see him, and immediately posed the question, "Machiavelli, are you ready to meet your maker?"
There was silence. The bishop then asked. "Machiavelli, do you confess your sins?" The silence was deafening. Undaunted, the bishop continued, Machiavelli, do you renounce Satan? This time Machiavelli responded in a loud, clear voice: "This is no time to make enemies."

In reflecting on my own almost 60 years of activism needed to create a profession where there was none, in which the APA openly spent 10 years demonizing me, when professors to their graduate students referred to me as Psychology's Great Satan, it would seem a bit late for me to worry whether I am making enemies. So please be forewarned that what you are about to hear is extreme. But extreme times require an extreme response. At an extreme moment in the history of America, Martin Luther King, Jr. exclaimed, "The question is not whether we will be extremists, but what kind of extremists we will be… The nation and the world are in dire need of creative extremists." On a more modest scale, and one close to home, psychological practice is languishing and is in danger of extinction, requiring creative extremism before it is too late.

I know who I am, a lifelong dedicated practitioner who entered private practice in 1948 and was one of the World War II veterans who became interested in psychology from their war experiences, entered graduate school, and subsequently carved out a profession where there was none. Preceding us there were less than 200 psychologists in private practice, almost all women with masters degrees seeing only children. We entered doctoral programs that had been created at the behest of the V.A. and NIMH, with the reluctant cooperation of psychology departments who hated the subject but welcomed the federal money and the bonanza of students on the G.I. Bill. They used most of this money to enlarge their experimental/research programs, and we found to our dismay that clinical programs had little or no clinical substance. We literally bootlegged our training by secretly paying friendly psychiatrists to teach us at night and weekends. Soon we were paying them in kind by providing psychological testing, something that was being taught in our clinical programs. Had our professors gotten wind of this arrangement, or even that we were contemplating independent practice upon graduation, we would have been dismissed from the

program as this was happening to fellow students who complained of the lack of clinical training.

The success of psychological interventions on the front lines in WW II had aroused a sudden interest among the public in psychotherapy, creating a shortage of psychiatrists, and soon they were giving us their overflow patients. This is how, unbeknown to our professors, we surreptitiously slipped into private practice. Once we moved on from our secret psychiatrist mentors, things were tough, inasmuch as there was no societal recognition of psychologists, as well as an absence of licensure, third party reimbursement and malpractice insurance. Amazingly we succeeded by charging $10 an hour while psychiatrists charged $15. In my own case a prospective patient would want reassurance I was a psychiatrist. When I responded that I was a psychologist, the caller would back away. I would invite them to come in for a visit, and if the caller concluded it was not worthwhile, there would be no charge and that would end the matter. But for only a few exceptions, the prospective patient found help in that first session and continued.

In the succeeding years, and against all odds, a handful of extremist known as the legendary Dirty Dozen forged a profession, having to fight all the way not only the American Psychiatric Association, but our own APA (Wright & Cummings, 2000). Our academically controlled profession opposed the very concept of independent practice, fighting in the state legislatures our attempts at licensure, while in health circles they spoke against third party reimbursement for us. The same vehemence of this is now replicated as academia opposes prescription authority. In the mid-1960s when one APA board member was asked why he was so opposed, he smugly replied, "I will not lift one finger to put another nickel in the pocket of a private practitioner." Colleagues, this attitude has not changed, but in most instances a "scholarly" veneer has been added in effective obfuscation of the underlying naked hostility. B.F. Skinner (1999) said it in his farewell address to the APA delivered weeks before he died. At one point he interrupted his own speech and surprisingly admonished professional psychologists "…they hate you and there is nothing you can do to change that." I was in the auditorium and can still hear the gasp from the audience.

I believe I know who you are. You are dedicated practitioners who love your profession, but are dismayed by the APA's inability to restore professional practice to its rightful, integral place in the nation's health system. You saw your expensive dues being squandered in "hobby projects" without results, you resented the special assessment levied against members who are licensed, and you were outraged to learn that the ineffective head of the APA Practice Organization was being paid an annual salary of $640,000. You have quit the APA, you are thinking about quitting the APA, or you are maintaining your membership because you erroneously believe that leaving APA would jeopardize your malpractice insurance. One must be a member to obtain APA insurance, but one does not have to be a member to continue it, a fact our national organization does not disclose unless asked directly.

I also know who our young colleagues are. They have a Disneyland view of practice imbued in them by their pseudo-clinician professors who tell them building a private practice is easy: just look at me. But anyone can obtain the one or two patients that professors see, if they see any at all, whereas building a fulltime practice takes work, dedication and time. In many cases we have recruited our own patients who followed in our footsteps as a substitute to resolving their transference toward their therapist. Too often they are the personality disordered and frequently intractable patients that seemingly so intrigue psychotherapists that they continue to see them interminably and eventually encourage them to join us as colleagues. Young practitioners take licensure, third party payment and societal recognition for granted, believing these were always there, knowing nothing of the 30 years of fighting it took to obtain these. Like their mentors, they are economic illiterates, and don't even realize that practice is a business rather than an eleemosynary endeavor. They are determined to do good deeds, but that is hard to do when you cannot even meet your overhead or your student loan payments. In short, professors admit students who are in their own image. Our graduates are not only economically illiterate, but they resemble nuns more than they resemble doctors. As one who has the highest regard for the dedication and self-sacrifice of nuns, I am, nonetheless grateful one is not flying the airliner I am on or surgically removing my tumor. When I ask professors why they don't tell prospective students the truth about declining practice, they respond, "Oh, no, that would scare students away." They fail to add, "…and that would cost me my job."

The Scientist/Professional Model: Our Sado-Masochistic Marital Vow

Shortly after I entered private practice in 1948 I was called as an expert witness on behalf of a severely battered woman I was seeing. There was no psychology licensure then and a sympathetic judge did his best to qualify me as an expert. I was unable to respond to his questions about a core curriculum for clinical psychology, to say nothing about the lack of competency standards. In the end I was allowed only to testify I had seen my patient's severe injuries, but not being an expert witness, I could not testify they were inflicted by her husband. Discouraged, I nonetheless brightened up when I learned the following year there would be a conference in Boulder, Colorado to establish a core curriculum. Sadly, however, the Boulder Conference concluded that the science of psychology had not sufficiently progressed to allow a profession of psychology, and that psychologists must be trained primarily as scientists and only secondarily as professionals. Thus, a core curriculum was superfluous and the idea was rejected. Called the Scientist/Professional Model, there have been over 80 similar conferences since Boulder, all of which except one have rejected a core curriculum as a threat to academic freedom. Thus the unconscionable stricture that the profession is not mature enough to exist independently of our academic guardians still prevails (Benjamin, 2001), and recently has been reiterated in belligerent form in the so-called "Flexnor Report" issued by the Association for Psychological Science. Interestingly, this historian (Benjamin) who chronicled psychology's repeated rejection of a core curriculum failed to even mention the Vail Conference (early 1970s) which grew out of the professional school

movement, and which outlined explicitly the Professional Model. The APA has not only failed to implement the recommendations of Vail, which did outline a practice core curriculum, but it seemingly buried all memory of it. No wonder: we stack our curriculum and competency conferences with the preponderance of scientists and academic pseudo-clinicians and then wonder why we get nowhere.

We as practitioners have for six decades passively allowed this Boulder Model in spite of its having been demonstrated that it produces mediocre scientists and less than skilled practitioners. It would be easy to call this our dodo-syndrome, but it is far more than that. Like a battered woman who clings to her brutal husband, we have a sado-masochistic marriage to the Scientist/Professional Model, putting academic pseudo-clinicians in charge of not only training, but determining who gets trained, and ultimately determining how we should practice. Let us look at this egregious track record (Wright & Cummings, 2000):

- Academicians fiercely opposed psychology licensure, necessitating 25 years to go from the first state (Connecticut in 1952) to the last (Missouri in 1977). It could have been done in one-third of the time if academic-scientific psychologists did not, state by state, oppose us in the legislatures, resulting in legislators time and time again denying licensure and telling us to go home to get our act together.
- APA President Jerome Bruner failed in 1965 to sign and transmit the letter as agreed upon by the APA, the Dirty Dozen and Health Secretary Joseph Califano that would have made psychologists Medicare providers. Consequently, it was 25 years later (1990) before psychologists were granted that status, and then in a more limited capacity than that which was within our grasp in 1965 (Wright & Cummings, 2000).
- Our academic colleagues opposed our going into private practice, telling society we were not qualified to practice independently.
- They cautioned third party payers that reimbursing psychologists would open a can of worms, leading to lawsuits and discredit
- They consistently published questionable research that purported to demonstrate psychotherapy was no more efficacious than faith-healing or religious conversion. The popular press loved these and gave them broad coverage, much to the dismay of those of us trying to make a living as psychotherapists.
- They prevented practicing psychologists from holding faculty posts, and when the professional school movement knocked down that barrier, they "complied" by appointing academic pseudo-clinicians.
- They never raised a finger to help in our struggle for hospital privileges.
- Through its often irrelevant accreditation program it captured the professional schools and transformed them into their own image. This is another instance of practitioners passively acquiescing to the scientist/professional model.

- At the present time they fiercely oppose prescription authority and write letters saying that as psychologists we unequivocally believe psychologists are not qualified for RxP. And much harm would befall the American people. The most recent was a signed petition by leading academic clinicians to the governor of Hawaii and the legislature of Missouri.

Yet in the face of all this, most practicing psychologists passively accept the Boulder Model as inevitable, while some even continue to believe in it. This is our sado-masochism.

We Are Not a Healthcare Profession

Taking advantage of the deep wounds inflicted on us by psychiatry when we were forging a profession, our academic/scientific colleagues have bamboozled us into thinking we are not, and should not be a healthcare profession. So pervasive has been this brainwashing that the fastest way to get a colleague to backtrack is to cry out, "Why, that's the medical model!" One automatically retreats, seemingly in shame. Our having let ourselves be so deceived has excluded us from our rightful place as an effective, integral part of our nation's health system. In the eyes of one historian, this abrogation, coupled with questionable and highly publicized debacles (e.g., multiple personalities, recovered memories of incest, rebirthing, victimology, reprogramming therapy, past lives therapy) have so lowered the respect of society that we are literally the only American occupation that has never had a commemorative postage stamp (Benjamin, 2001; Cummings & O'Donohue, 2008).

Nursing, once the lapdog of physicians, no longer sees itself as part of medicine, but as part of *healthcare.* Likewise, so does dentistry, podiatry, optometry, pharmacy and every other doctoral level healthcare profession, and all have prescription authority and an important role in the healthcare system except psychology and social work. This is now called the *health system*, not the medical system. By opting ourselves out of the health system it is no wonder that we are underfunded, underpaid, and underappreciated because the nation pays for healthcare, not mental healthcare. In contrast look at nursing that began as a para-profession to medicine, has now upgraded its nurse practitioners programs from the MA-level to the doctorate, and are destined to become the de facto primary care physicians by addressing the acute shortage of PCPs inasmuch as only 2% of medical school graduates are going into primary care. In the meantime, it matters not to our academia that the percentage of the national healthcare budget that that goes to mental health dropped from over 8% to 1.5% if one subtracts the portion that goes to psychotropic medication (Nemko, 2006).

Why has it behooved academic psychology to reject healthcare? In a number of ways academia has profited off of professional psychology, all the while opposing its progress for reasons of its own, which can be summed-up as disinterest and inability. Let us specifically address each.

- Academic psychologists are interested in their theories and their research and are disinterested in and unable to teach healthcare if called upon to do so. Especially this is true of psychopharmacology.
- The highly successful model of 1969-1976 at the California School of Professional Psychology in which all instruction was part time was scrapped at the behest of APA accreditation which requires full time faculty. The original design enabled CSPP to so flourish economically that it plowed back 20% of its income into scholarships. Each class was taught by someone who made his/her living doing what was being taught, thus not only providing the epitome of practical knowledge, but saving CSPP from unnecessarily expensive fulltime tenured professors. The professional schools have abandoned their promise and have become "me-too" APA approved traditional programs, churning out thousands of masters degrees to stay economically viable.
- As presently constituted, the majority of psychology doctoral students are in clinical psychology, and their numbers support the other doctorates (e.g., behavioral analysis, social and experimental psychology, I/O psychology).
- Terminal masters programs are cash cows for psychology departments, so as early as the 1970s they successfully opposed any efforts to adopt the California licensing model in which MA-level practitioners would practice as psychological assistants under the direction of licensed psychologists. This would have been similar to how physician assistants work in medicine. However, this would have drastically reduced the number of students seeking such a career, curtailing academia's cash cow.
- It matters not to academia that there is now a glut of over 750,000 MA-level psychotherapists, most of which were trained in psychology departments and professional schools. Managed care panels are composed largely by such masters psychotherapists, and because the APA has failed to demonstrate the value-added of the PhD, the pay scale for psychotherapy is a sub-doctoral one for psychotherapy.
- Since professional psychologists comprise the majority of the APA membership, we are paying a disproportionate amount of the money through our dues to support the vast number of esoteric psychology journals with little readership so that academics can publish, thus assuring tenure and eventual promotion to the rank of full professor. By the way, the term "fulltime professor" is not only a misnomer, but a costly one as well.

A Proposal: A Redefined Profession

The paradigm shift about to be proposed may at first be seen as extreme, until one realizes it is the simple and logical structure found in all healthcare professions except our own.

Each health profession determines its own direction, but derives knowledge from science and applies it as it pertains appropriately to practice. Biology and its many scientific derivatives (physiology, chemistry, embryology, genetics, etc.) is the scientific basis for practice in all healthcare, providing knowledge but not dictating

practice. In healthcare each profession determines its own practice procedures, deriving knowledge from science, and supplementing it with the practical (practice) research that is necessary and that scientists are incapable or disinterested in doing. Thus the biological sciences supply the physiological and anatomical basis, but they do not dictate, for example, how a surgeon removes a patient's appendix or transplants a heart. Medicine, nursing, dentistry, podiatry, optometry are dependent upon the biological sciences, but it is each professions responsibility to determine how knowledge is translated into practice. Not so in psychology, where for six decades academic psychologists have dominated our accreditation, training, certification, licensure and all too many other aspects of what should be determined by practitioners, all the while denying us the core curriculum that would advance practice and increase societal respect and appreciation.

Additionally, all healthcare uses different names for the science than for the practice. Biologists contribute to medicine, but they do not call themselves physicians, and conversely physicians do not call themselves biologists. It is time to break the stranglehold this overlapping has placed on our practice. Psychology should continue to be the science for the psychological professions, but the practice itself should be called *behavioral health.* A new degree is called for, *doctor of behavioral health* (DBH), freeing it from the plethora of irrelevant requirements the APA imposes on the PhD and even the PsyD. The mission is to train behavioral care providers who are skilled practitioners as well as intelligent consumers of science, something all other healthcare professions have been doing all along. The DBH would be an integral part of the health system, serving in all healthcare settings, and serving as primary behavioral care providers (BCPs) right in the primary care setting with PCPs with co-equal importance. It is time also to end the internecine warfare among several so-called psychological professions, all of whom purport to do psychotherapy and are independently licensed: clinical psychology, counselors, social workers, marriage and family therapists. These should be given the opportunity to upgrade to the DBH, placing all behavioral health practitioners on the doctoral level., and in keeping with the intent we are to serve as primary behavioral care practitioners (BCPs) side by side with primary care physicians (PCPs).

The good news is that such a program exists (Cummings, 2008). It was launched in the 2009-2010 academic year by the forward-looking, innovative Arizona State University with 57 practicing MA-level psychotherapists with an average of 7.4 years of experience (O'Donnell, 2009). Ronald O'Donnell, Ph.D. serves as director, and Janet Cummings, Psy.D. as his co-director. And there is continued good news, as the NAPPP has established accreditation and certification boards to usher in the new era (Caccavale, 2009a; 2009b). After years of inertia, practitioners are beginning to take rightful possession of their profession. Let us not allow this momentum to be derailed as was the case in the professional schools.

The Science of Psychology: An Addendum

It may startle many to hear this author state that scientific/academic psychologists have a right to be doing what they have been doing. It is we practitioners who have been derelict in not taking charge of our profession, while allowing the scientist/professional model through academia to take charge of our destiny and run it into near extinction. After doing so, they now complain we are inadequately trained, but who trained us? The dictum "let a thousand flowers bloom" (Benjamin, 2003) is appropriate for science. This is how science progresses, with competing theories often in contentious disagreement. On the other hand, practice requires standards and procedures that meet the needs of practice and the patients it serves. But a realistic assessment of how little useful knowledge scientific/academic psychology has really contributed to practice needs to be stated.

None other than past APA president Ronald Fox (2003), in lamenting the paltry contributions of psychology to the understanding of such imperatives as poverty, violence, why our children do not learn, and societal disorganization in general, laments that our research has been obsessed with "picking lint out of our navels." This scathing assessment is not alone, as the list of similar observations compiled by Cummings and O'Donohue (2008) discloses.

In a publication soon to appear, none other staunch academician Larry Beutler (2009) concludes the following:

I became convinced that scientists were intentionally obscuring many important results because of an unwarranted devotion to a limited number of scientific methods. In fact, I came to believe that they may be using methods and defining psychotherapy and research informed practice in ways that hindered clinicians from being optimally effective (p. 301).

And:

The degree that the effort to identify EST or research-informed psychotherapies is viewing evidence through a single or preferred research methodology, when there are several competent methods available, is the degree to which the scientist has fallen prey to worshipping the method rather than the "truth" (p. 302).

No small wonder that practice has been declining both economically and in the eyes of the general public. It is time we shake off the shackles!

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